

# HEALTH CARE REFORM

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Health Care Reform, Serial No. 103-...

## HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

### VOLUME III

#### Consideration of Benefits for Inclusion in a Standard Health Benefit Package

MARCH 30; APRIL 22, 1993

### Serial 103-14

Printed for the use of the Committee on Ways and Means



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# CONSIDERATION OF BENEFITS FOR INCLUSION IN A STANDARD HEALTH BENEFIT PACKAGE

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TUESDAY, MARCH 30, 1993

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 1310A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[Press releases announcing the hearings follow:]

**FOR IMMEDIATE RELEASE  
MONDAY, MARCH 15, 1993**

**PRESS RELEASE #8  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-1721**

**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES A HEARING  
ON  
HEALTH CARE REFORM:  
CONSIDERATION OF BENEFITS FOR INCLUSION IN A  
STANDARD HEALTH BENEFIT PACKAGE**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing to consider benefits to be included in a standard health benefit package. This hearing will be held on Tuesday, March 30, 1993, beginning at 10:00 a.m., in 1310 Longworth House Office Building.

In announcing this hearing, Chairman Stark said, "A number of proposals have been put forward that would establish a standard or uniform health benefits package for all Americans. This hearing will provide an opportunity to begin consideration of benefits and services that should be included in such a package."

Oral testimony will be heard from public witnesses. If the Subcommittee is unable to accommodate all organizations wishing to testify on Tuesday, March 30th, future hearings on this topic may be scheduled. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

**DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:**

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than the close of business on Monday, March 22, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff [(202) 225-7785].

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 200 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

**(MORE)**

**WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:**

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business Tuesday, April 13, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

\*\*\*\*\*



FOR IMMEDIATE RELEASE  
WEDNESDAY, MARCH 31, 1993

PRESS RELEASE #10  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES AN ADDITIONAL HEARING  
ON  
HEALTH CARE REFORM:  
CONSIDERATION OF BENEFITS FOR INCLUSION IN A  
STANDARD HEALTH BENEFIT PACKAGE

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The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold an additional day of hearings to accommodate public requests to testify on the consideration of benefits to be included in a standard health benefit package. This hearing will be held on Thursday, April 22, 1993, beginning at 9:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

The April 22 hearing is a follow-up to the hearing announced for March 30, 1993. Testimony will be received only from public witnesses who have already requested to testify in response to the March 15, 1993, press release. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing. (The hearing was announced and the scope of the hearing was described in press release #8, dated March 15, 1993.)

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business Monday, May 3, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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Chairman STARK. Good morning.

The subcommittee will continue today its series of hearings on health care reform, attempting to lay the foundation to help us work with the President to enact health care reform legislation.

A number of proposals that have been put forward would establish a standard uniform health benefits package for all Americans. This hearing will provide an opportunity to begin consideration of benefits and services that should be included in such a package.

Today, we will consider the implications and complications associated with establishing a standard health benefit package for all Americans. This issue is one of the many complex components of a possible health reform plan.

Unfortunately, we were unable to accommodate all witnesses wishing to testify at today's hearing. More than 60 individuals and organizations requested to testify on this topic. We will schedule a followup hearing in the near future to hear from all of those who were unable to testify today.

The minority had a conference meeting and I want to make sure that my ranking member has an opportunity to present his statement. I think, in the interest of time, we will proceed with the members who are present and recognize Mr. Thomas at the completion of members' testimony for his opening statement which will appear in the record in its entirety at this point.

[The opening statement of Mr. Thomas follows:]

#### OPENING STATEMENT OF HON. BILL THOMAS

The success of health reform will depend as much on the details of the initiative as the major component parts of the plan the Congress may finally enact. Today, the Health Subcommittee will examine one of the most vexing of these details, the benefits package.

Whether health reform should dictate a set of benefits for all Americans is a key question that we cannot avoid. However, even if it makes sense conceptually to have such a mandated package, and I am not prepared to say it does, we cannot ignore the political and practical feasibility of the federal government or its designated agency enfranchising certain benefits and not others.

Mr. Chairman, the breadth of interest in this hearing and the one that will follow on this subject next month illustrates the difficult task this Subcommittee faces in setting policy for health benefits. We should remember a key question as we consider policy regarding benefits, will the changes the Congress enacts make the average American with coverage better or worse off?

The Congress makes policy in the aggregate, but the individual can only judge reforms based on the effect on themselves and their dependents. If health reform makes more people worse off, then we will have to "hold on to our hats" as we head into another Medicare Catastrophic.

Mr. Chairman, this hearing should provide a useful start. I hope we will remember the pitfalls as we consider the changes.

Chairman STARK. The Chair would like to state at the beginning that we are going to be somewhat more generous than the White House and give people 5 minutes in which to summarize their testimony, instead of 3, and expand upon it as they choose. Without objection, all of the testimony prepared today will appear in the record in its entirety.

With that, we will proceed, and I recognize the Honorable Nita Lowey from New York, who is chair of the Task Force on Reproductive Choice for the Congressional Caucus for Women's Issues.

Nita, welcome to the committee. Why don't you proceed.

Ms. LOWEY. Thank you.



Chairman STARK. If you would suspend for just a moment, our colleague, Dr. McDermott, has a few words of wisdom for us. So I will recognize him and any other members who wish to add to the record at this point.

Mr. McDERMOTT. Thank you, Mr. Chairman.

I just want to say that it is important for all of us to understand that limiting benefits is not a way to achieve cost containment. We have to address the problem of cost directly and we must assure that all Americans have access to the medical care they need.

None of us could tolerate the uncertainty of wondering whether a particular visit to a doctor or a hospital came within the benefit package. Americans need the security of knowing that their coverage is stable, predictable, and continuous.

Secondly, we cannot tolerate a two-tiered system of health care delivery, where those that can afford it have every incentive to buy out of the system, because the system is not good enough. In this case, our interest and our principles are in harmony. In every other country where the benefit package is narrowly defined, the costs of benefits outside the core package escalate out of control. The vicious cycle of cost shifting and price inflation in the private sector and service reduction in other sectors just renews itself, and we have been fighting that for years here.

I believe we can design a system that meets Americans' legitimate expectations for benefits in a cost-effective way that guarantees all Americans the health care we deserve, and I think the process today is an important part of our discussion. We want to thank all of you for coming and participating in helping us put this together.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I understand, by agreement among the witnesses, that the Chair was to recognize the Honorable Olympia Snowe, our distinguished colleague from Maine, who is the cochair of the Congressional Caucus for Women's Issues, so I will accede to the order that the witnesses agreed upon. Olympia, why don't you lead off?

#### **STATEMENT OF HON. OLYMPIA J. SNOWE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE, AND COCHAIR, CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES**

Ms. SNOWE. Thank you, Mr. Chairman.

On behalf of the Congressional Caucus for Women's Issues, I am very pleased to be here today with my colleague, Rep. Lowey from New York, who will be speaking on reproductive health care.

Mr. Chairman and members of the committee, I will be brief. I know you have a number of witnesses to appear before you today. But we appreciate the opportunity to testify on behalf of the caucus, because, more than anything else, we want to ensure that women are included at the onset during the health care reform proposal and debate that will emerge during this Congress.

Understand our frame of reference: It was only a few years ago that we learned that women were systematically excluded from clinical drug trials at our premier health research institute, the National Institutes of Health. So from that time forward, we are

trying to do everything that we can to ensure that women are included in the health care debate in all dimensions.

In that regard, the Congressional Caucus for Women's Issues adopted a set of principles that we believe should be included in the health care reform proposal. These were developed in conjunction with the Campaign for Women's Health, and I know they will be testifying shortly. I would like to submit the caucus' principles into the hearing record.

Mr. Chairman, 9.5 million women in this country had no health insurance in 1991 from any source. Half of these women were employed. In addition, women are more likely to work in part-time or temporary jobs, and these are two groups that are less likely to have access to health care coverage.

Women also have health care needs that differ significantly from men. Women's health can be defined as diseases or conditions that are unique to or more prevalent among women, or require different interventions or treatments.

Diseases unique to women, such as breast cancer and other reproductive tract cancers, require special research and special services. Women also have unique health concerns with respect to family planning and childbearing, as well as pregnancy.

Older women face more long-term chronic diseases than men and live with them for longer periods of time. That is why chronic care services and prescription and nonprescription drugs are so essential to older women.

Women's mental health needs often have been ignored. Women suffer twice the rate of clinical depression as men; yet, three-quarters of the women who suffer from depression never receive treatment.

These and other health problems, such as heart disease and eating disorders, may require different treatments or interventions in women. So not only must access to health insurance for women be increased, but the coverage provided by this insurance must also respond to the unique and special health care needs of women across their entire lifespan.

Today's hearing is to discuss what should be included in the standard health benefits package, and I would refer you to the caucus' eight principles, one of which states that any basic health benefits package must include preventive, diagnostic and treatment services for women, and such services should include, but not be limited to, prenatal care and delivery services, mammography, pap smears, family planning services and substance abuse services. Well-baby and well-child services should also be included. We also believe that a comprehensive reproductive health package, including family planning, pregnancy related care, and menopausal care should be provided.

Approximately 14.6 million women have no insurance to cover maternity services. Yet, it has been proven over and over again that appropriate prenatal and postnatal care does make a difference. The Office of Technology Assessment has indicated that every time we avert a low birth weight baby by improved prenatal care, we are saving anywhere from \$14,000 to \$30,000. Then we can also look at other women's health care needs. A Pap smear can detect cancer early on, as early as 10 years before invasive cervical



cancer develops. The survival rate of women with cervical cancer detected by a Pap smear approaches 100 percent. Additionally, 46,000 women die every year from breast cancer. Early detection is key to survival, yet we do not have universal access to mammography, and the Medicaid program does not mandate mammography coverage.

Another set of issues covered by our principles that are of concern to women is that health care services should be available in a wide range of settings, including home settings, hospice settings, outpatient settings, and long-term care settings.

It also should include another caucus principle that services should be available through a wide variety of providers, including physicians, nurse practitioners, nurse midwives, and physician assistants. Training programs should be encouraged, so that there are more women providers at all levels of health care.

I think, Mr. Chairman, that these two principles reflect the realities of many women's choices for providers, as well as settings. A woman is more likely to go to a gynecologist during her reproductive years, and as she gets older is more likely to seek an internist.

The problem with providers who get into specialties is that they don't see the entire spectrum of a woman's health care needs across her entire lifespan. That is why we have another health care principle that states that services should be based on individualized care appropriate to each patient. Public and provider education should be available to eliminate gender stereotyping, which results in inappropriate care.

Mr. Chairman and members of the committee, it has been shown with study after study that women who suffer from the same symptoms as men are less likely to receive aggressive treatment, less likely to receive extensive followup or extensive testing. Women's complaints are not likely to be treated seriously despite the fact that women are more likely to have chronic conditions that deserve individual attention and concern.

In the final analysis, Mr. Chairman, the eight principles that we have identified allow us to look at the benefits package from a different perspective than heretofore has been the case with health insurance in this country. And if you look at older women's issues, as well—and I won't get into details here today, but suffice it to say, if you look at osteoporosis, if we required bone mass measurement to identify osteoporosis and to identify treatments to prevent further loss, we would save billions of dollars in this country. As you may know, women are more likely to be afflicted with this disease than men. The fact is that 90 percent of women over the age of 75 are the ones who have osteoporosis.

If we look at the long-term health care needs, it is women who are primarily in nursing homes. There are 2 million residents in this country today, and 1.5 million are women. Women are also the primary care givers in this country.

So when we are looking at long-term health care as a dimension of this debate, we also have to look at these issues with respect to older women, because clearly they will make a difference. Mr. Chairman, from the beginning we must incorporate into the health care reform proposal women's health care needs throughout their lifetime.

Thank you, Mr. Chairman.

[The prepared statement and attachment follows:]



TESTIMONY OF CONGRESSWOMAN OLYMPIA J. SNOWE  
Subcommittee on Health  
Committee on Ways and Means  
March 30, 1993

Mr. Chairman, I want to thank you for giving our panel the opportunity to address the Ways and Means Subcommittee on Health about the importance of including from the very onset, women's health needs in any benefits package that is part of Congress's health care reform proposal.

To the Congressional Caucus for Women's Issues and the women of this country, this is a particularly salient issue, given the fact that not long ago it was discovered that our nation's premier health research system, the National Institutes of Health, had systematically excluded women from clinical trials and as a result, their special health problems were neglected.

Therefore, as Congress moves toward action on health care reform, it is vital that women's health care needs are addressed from the very beginning. In that regard, the Executive Committee of the Congressional Caucus for Women's Issues, working with the Campaign for Women's Health, has adopted a set of principles that we believe should be part of whatever health care reform proposal becomes law.

I would like to submit these principles for the record.

Mr. Chairman, sixteen million women in the United States had no health insurance from any source in 1991. Half of these uninsured were employed. In addition, women are more likely to be part-time or temporary employees, two groups of workers that have had limited access to insurance coverage.

Women also have health care needs that differ significantly from those of men. Women's health can be defined as diseases or conditions that are unique to women, more prevalent in women, or require different treatments or interventions.

Diseases unique to women, such as breast cancer and other reproductive tract cancers, require special research and services. Women also have unique health concerns with regard to family planning, pregnancy and childbearing.

Older women face more long-term chronic diseases than men, and live with them for longer periods of time. As a result, access to chronic care services and prescription and non-prescription drugs are of special significance to older women.

Women's mental health needs are too often ignored. Women suffer twice the rate of clinical depression as men; yet three-quarters of women who suffer clinical symptoms of depression never receive treatment.

Women are the fastest growing population with HIV with an estimated 80,000 women between the ages of 15 and 44 infected. By 1995 the Centers for Disease Control estimates that 75,000 women will have AIDS, compared to 26,000 today.

These and other health problems, such as heart disease and eating disorders, may require different treatment or interventions in women.

Thus, not only must access to insurance for women be increased, but the coverage provided by this insurance must respond to the unique and special health care needs of women across their life span.

Today's hearing is to discuss what should be included in a standard health benefit package. As such, I would like to refer to the second of the Caucus's eight principles which states that,

"any basic health benefits package must include important preventive, diagnostic, and treatment services for women. Such services include (but are not limited to): prenatal care and delivery services, mammography and pap smears, family-planning services, and substance abuse services. Well-baby and well-child services should be included. Where appropriate, outreach and follow-up services should be available."

We also believe that a comprehensive reproductive health package, including family planning services and supplies, pregnancy related care and peri-menopausal care should be provided since many of these services will benefit both women and men.

Approximately 14.6 million women have no insurance to cover maternity services. Yet it has been proven that appropriate pre- and post-natal care does make a difference. The Office of Technology Assessment estimated that the U.S. health care system saves \$14,000 to \$30,000 for every low birth weight birth averted by early or more frequent prenatal care. Prenatal care is estimated to save \$3 for every \$1 invested by improving infant health and reducing neonatal intensive care costs.

There is an old saying that an ounce of prevention is worth a pound of cure. This saying certainly holds true when it comes to women's health care needs. A pap smear can detect cancer in

early stages - as early as 10 years before invasive cervical cancer develops. The survival rate of women with cervical cancer detected by Pap smear approaches 100 percent.

More than 180,000 women were diagnosed with breast cancer in 1992 and 46,000 women died from the disease. Early detection is the key to reducing deaths from this disease. Research indicates that universal access to screening mammography would reduce breast cancer mortality by 30 percent. Yet our own federal health insurance program, Medicaid, does not mandate mammography coverage.

Another set of issues of concern to women's health covered by our principles is that:

"Health care services should be available in a wide range of settings, including outpatient settings, the home, hospice facilities, and long-term care settings."

And also that,

"Services should be available through a wide variety of providers, including physicians, nurse practitioners, nurse midwives, and physician assistants. Training programs should encourage more women providers at all levels of health care."

Mr. Chairman, these two principles reflect the realities of many women's choices for providers and settings. Women of reproductive age are more likely to see gynecologists than other providers, older women visit internists, and increasing numbers of poor women seek care in emergency rooms. Also, many older women who currently live in nursing homes could live on their own or with family members at much lower costs if attendant care and skilled nursing care were more accessible and covered by insurance.

In addition, the increasing specialization and compartmentalization of care in our society puts women at risk when the specialists who are providing primary care are not trained to fully assess a woman's health. For example, gynecologists may fail to recognize non-reproductive problems. On the other hand, even if specific concerns are identified, many women lack access to specialists or other appropriate providers.

Another important Caucus principle is that "services should be based on individualized care appropriate to each patient. Public and provider education should be available to eliminate gender stereotyping which results in inappropriate or missed diagnosis of illness in women."



Members of the Subcommittee, studies have shown that women receive less aggressive treatment or appropriate care than men with the same symptoms, who are often given more extensive tests and follow-up. Women are frequently viewed as complainers by medical providers and their complaints are not taken as seriously, despite the fact that women are more likely to have chronic conditions that deserve individual attention and concern.

The causes of the difference in treatment range from an underlying bias by physicians, lack of proper education and training, and the use of treatment, equipment and drugs developed on a male research model. On this last point, I would just like to mention that the Caucus has been instrumental in exposing this discriminatory research practice and have worked hard to ensure that women and minorities be adequately represented in clinical trials at NIH. As a result of these common problems encountered by women receiving treatment, training programs for physicians and other providers to eliminate this inequity of care are a necessary part of medical education.

Finally, I would like to address an important dimension of the issue of access to services for women. Women frequently cancel their own medical appointments when child care is not available or when the woman feels that she must attend to the needs of children or other dependent family members. If getting medical care means traveling across town with children, many women opt to stay home.

Community-based health care with the availability of support services such as transportation or assistance in finding child care services, as opposed to care that is available only in a hospital or medical center setting, would increase the likelihood that women seek care for themselves. In light of this reality, another important Caucus principle states,

"Primary care services should be community-based. Where appropriate, support services such as transportation, language translation, and child care arrangements should be available to assure access. Wherever possible, pediatric and maternal care should be coordinated."

Mr. Chairman, the eight principles that we have identified allow us to look at a benefits package from a different perspective than in the past, when coverage for women and children, if provided at all, was added on to a male employee insurance as dependent coverage.

Within the context of women's health needs we also need to look at the issues facing older women. Because of an erratic work history, a precarious financial situation or simply because they live longer -- many mid-life and older women face a system that does not meet their basic or special health care needs.

Twenty million women in this country suffer from Osteoporosis. It is a progressive bone disease which afflicts 50 percent of women over the age of 45 and 90 percent of women over 75. More than 1.3 million bone fractures per year are attributable to this disease and the direct medical costs of these fractures is \$10 billion a year and rising.

Bone mass measurement is the only accurate way to detect and diagnose low bone mass for the purpose of determining the risk of bone fractures and selecting therapies to prevent further loss. Yet Medicare only provides reimbursement for one outdated technology.

Long-term care is another important issue. I realize that this issue, itself, is worthy of its own hearing. I just ask, therefore, that the Subcommittee consider the following facts when reviewing long-term care proposals:

- Of the nearly two million nursing home residents, 1.5 million are women
- Forty-one percent of non-institutionalized women over 65 live alone, compared to 16 percent of men and of these, five women have incomes below the federal poverty level for every one man.
- Women outnumber men in Medicare by a ratio of three to two, making Medicare a vital program for older women. Medicare pays only limited skilled nursing home and in-home long term care.
- Over 80 percent of the care needed by the frail elderly is provided by family caregivers, 70 percent of whom are women.

Through my testimony and the testimony of the other Congresswomen, we hope that you will realize that it is imperative to include in the basic health benefits package the health needs of women from the beginning -- not just have them tacked on at the end as if they were simply an afterthought. Let us take advantage of this historic opportunity and create a benefits package that truly benefits all Americans.



## **Congressional Caucus for Women's Issues**

### **Statement of Women's Health Principles**

- 1) Health care coverage should be available to all, regardless of income, employment status, pre-existing conditions, or eligibility for other forms of public assistance.
- 2) Any basic health benefits package must include important preventive, diagnostic, and treatment services for women. Such services include (but are not limited to): prenatal care and delivery services, mammography and pap smears, family planning services, and substance abuse services. Well-baby and well-child services (through adolescence) should also be included. Where appropriate, outreach and follow-up services should be available.
- 3) Women must have access to full information, including referrals, about all treatment options and alternatives to treatment in order to make informed choices.
- 4) Health care services should be available in a wide range of settings, including (but not limited to): outpatient settings, the home, hospice facilities and long-term care settings.
- 5) Services should be available through a wide variety of providers, including physicians, nurse practitioners, nurse midwives, and physician assistants. Training programs should encourage more women providers at all levels of health care.
- 6) Services should be based on individualized care appropriate to each patient. Public and provider education should be available to eliminate gender stereotyping which results in inappropriate or missed diagnoses of illness in women.
- 7) Primary care services should be community-based. Where appropriate, support services such as transportation, language translation and caregiving arrangements should be available to assure access. Wherever possible, pediatric and maternal care services should be coordinated.
- 8) Health care reform should include research on the best way of promoting health and preventing disease in women, including data on health and illness in women, service delivery modes best suited to meeting women's health care needs, health consequences of women's social and economic roles.



Chairman STARK. Thank you. I hope you can be with us for a few minutes and we will hear from Congressman Lowey at this point, and then the Members can inquire.

Would you like to proceed, Nita?

**STATEMENT OF HON. NITA M. LOWEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK, AND CHAIR, TASK FORCE ON REPRODUCTIVE CHOICE, CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES**

Ms. LOWEY. Thank you, Mr. Chairman.

I want to thank you for the opportunity to come before the Health Subcommittee to stress the importance of insuring that health care reform incorporate the needs of women. Women's health concerns have been on the back burner much too long, and we must seize this opportunity to guarantee equity in health care once and for all.

We are indeed faced with an historic opportunity to design a health care package that will improve reproductive health care for all Americans.

When you ask most Americans what priorities should be given attention in health care reform, preventive services are always high on the list. Prevention is both cost-effective and important from a quality of life perspective, and certainly there can be no more fundamental kind of preventive care than reproductive health services.

A reproductive health package must provide benefits for women and men throughout their lives, with an emphasis on prevention and wellness care. Indeed, we must insist that a "medically necessary or medically appropriate" standard be defined broadly to include prevention, health promotion and reproductive health services. This is all the more important when you consider that whatever package is produced will be applicable to all Americans and may be the only source of health care services available.

Our task then is to define a package which includes all services that are necessary or appropriate for the maintenance and promotion of women's health. This package must include coverage for pregnancy, childbirth and related medical conditions, including family planning and abortion services. We cannot continue to maintain a system that discriminates between childbearing and contraceptive choices. Failure to cover abortion services would relegate this legal service once again to the back alley, and would put women's lives at risk.

In the shift toward a cost-conscious health care system, we must emphasize primary and preventive care. For women's reproductive health, that will mean periodic gynecological exams, with particular attention to screening for breast and reproductive cancers and sexually-transmitted diseases. For men, increased access to screening for prostate cancer will be needed. This will also mean comprehensive prenatal and postnatal coverage.

Comprehensive coverage of preventive measures such as these is definitely most cost-effective. As we reverse health insurance trends that have short-changed women, we will actually save health care dollars. Federal family planning, for example, saves over \$4 in health and welfare costs for every public dollar invested.

Last year alone, that meant over \$500 million in health care savings for the Nation.

You may already be aware that over one-quarter of women of childbearing age, over 14 million, have no insurance to cover maternity services. This is truly a disgrace that leads to high infant mortality and lower productivity. It also literally robs many children of their opportunity to succeed. Ensuring full coverage of pregnancy-related medical care, including prenatal, childbirth, abortion, and postnatal care, will improve family health and ensure that each child born in this country has a real chance to achieve his or her fullest potential.

Guaranteeing coverage of a broad range of reproductive services is also perhaps the most important way of ensuring that our young people have access to health care. For example, for 85 percent of patients at title X family planning clinics, this is their only source of health care. For many, family planning services become their first access to our health care system.

We recognize that broad coverage of reproductive care is likely to be controversial. However, the Women's Caucus feels that the full range of reproductive care must be an essential part of the health care package. We are willing to work with you, Mr. Chairman, and with the President and his task force on developing the best way to include comprehensive reproductive health services, including abortion services, in a health care reform package.

Making comprehensive reproductive care an integral part of a benefits package is a critical step toward insuring that women's health is equitably addressed. In doing so, all American families will benefit.

I would like to submit for the record, Mr. Chairman, a list of services we consider crucial to providing reproductive care to women and men.

Thank you again for the opportunity to highlight issues that are of critical importance to women.

[An attachment to the prepared statement follows:]

#### HISTORIC OPPORTUNITY FOR A REPRODUCTIVE HEALTH BENEFITS

The design of a new benefit package offers a unique and historic opportunity to turn around the way reproductive health care has been delivered in this country. Today, women and men, find a fragmented system of services, inconsistent coverage from plan to plan, and state to state for routine preventive and reproductive health care. We have the opportunity to create a comprehensive package of reproductive health benefits for men and women throughout their life span.

A reproductive health package would include:

##### *Family Planning Services*

- contraceptive services and supplies
- voluntary sterilization
- basic infertility services
- screening for sexually transmitted diseases
- screening for cervical, breast, prostate cancers
- preconception risk assessment and care;
- related diagnostic, education and counseling

##### *Pregnancy-related Care*

- maternity care, including prenatal, delivery and postnatal gynecology;
- termination of pregnancy/abortion services

##### *Post Reproductive Care*

- screening for cervical, breast, prostate cancers
- osteoporosis risk assessment, counseling and education

Chairman STARK. I want to thank the witnesses.

Dr. McDermott, would you like to inquire?

Mr. McDERMOTT. I have nothing, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Mr. Chairman, I do not have any questions, but I very much thank my colleagues for putting before this group the importance of comprehensive reproductive services without the government specifying which of those services they believe are appropriate at any particular time.

It is extremely important that national health care provide access to all appropriate services, without regard to the variety of controversies about appropriateness that dominate our political horizon at this time.

Thank you.

Ms. SNOWE. I would just like to respond to the gentlelady by saying that she was also helpful in developing the health care principles as part of the caucus, and we appreciate that.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

I would like to ask our two witnesses who have obviously provided a very detailed recommendation for what should be included in the package: I am beginning to think the problem in deciding the basic benefit package will be trying to determine what is superfluous, not what is necessary, and I would like to hear either one or both of you tell this committee what you think should not be included in a basic benefit package that might be in some of the more generous health packages that we see in the workplace today.

But given the inevitable choice that we will have to make or somebody will have to make, what should probably not be in the core benefits package? Would you like to go first, Olympia, due to your seniority, on this issue?

[Laughter.]

Ms. SNOWE. Right. Thank you, Mr. Chairman.

Obviously the question you posed is going to be a matter of debate and that is going to be a difficult debate. I think we have found in the past some of the mandates that have been imposed on health insurance at the State level, for example, might not be necessary for a specific individual, and we hope that people do have choices.

But I think, obviously, we want to make sure that people have access to appropriate and necessary physician and hospital care. So we are here today to make sure that women are not excluded from the kind of care that will be important, so I think that is exactly what we are talking about.

Now, we can get into what might be superfluous, but I do not think that is really what—

Mr. GRANDY. Well, am I hearing you say in your careful response to my question that you would like to see a menu of benefits from which individuals might be able to choose? In other words, a core benefit package which would allow some substitution?

Ms. SNOWE. No. I guess what I am saying is that, obviously, people would like to have some choices about what they make. It remains to be seen what approach will be taken here in the Congress



or what the administration will be proposing, but we know that there are a variety of proposals.

The question is, if we were to require the creation of a standard benefits package, then it is also going to be a matter of debate of what is included in that standard benefits package, and if anybody wanted something in addition to that, then obviously they will have to pay for it.

Now, there are other ways of approaching it. Requiring the States to offer a standard benefits package that businesses could purchase for their employees or employees could buy into. But I think it is important to provide the appropriate level of care that is needed through the various providers in various settings.

Mr. GRANDY. Nita.

Ms. LOWEY. Mr. Grandy, I would like to respond to you by saying, as we are reviewing the various processes, some of which may be more controversial than others, that it is important that we emphasize certain principles, as I have tried to do in my presentation—number one, prevention, and number two, wellness, keeping people healthy.

For example, several years ago we had a difficult battle here about coverage under Medicare for mammographies, even though early mammograms are cost-effective and save lives. After a good deal of debate, mammography did become a covered item under Medicare. I think if we review the various options, we have to look at prevention, wellness, and keeping people healthy.

Many of us are aware of the difficult decisions that Oregon made and which were approved, where they listed certain items from, I believe, 1 to 658, and they decided to go up to something like 500. There may be certain processes to which you are referring that may not be cost-effective, they may not be keeping people healthy, and could be considered not to be reimbursable.

But what I would like to focus on is prevention, wellness, and women's health. Women's health has been neglected far too long. In fact, as a new member of the Subcommittee on Labor, Health, and Human Services of the Appropriations Committee, and as a member of the Women's Caucus, I know that just a few years ago only 13 percent of the budget at NIH was focused on women's health. This was an outrage we worked hard to address.

So if we can invest in keeping women and men healthy and cover those procedures that will be cost-effective, I think we save a lot of money in the long run.

I was astonished to learn the numbers of women that don't receive basic maternity care. Then we have the problem of babies being born that have all kinds of illnesses and the mother does not get the appropriate treatment.

So to go back to your initial question: each process has to be reviewed with an eye toward prevention, affordability, and cost-effectiveness. We can cut out, perhaps, some procedures that do not meet those important criteria.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank the witnesses. I do want to sort of give you the good news/bad news routine. The good news, of course, is that inasmuch as we know about the formulation process that is going on

at the White House, it does appear that the areas of primary care, of women's issues, of mental health, and of children's issues are getting far more attention, as they try and design an administration package. I have confidence that the First Lady will not leave these issues off the table, when we are sent a bill. That is the good news.

Now, the bad news is that if you look at our record, this committee is advised by two principal groups, the Physician Payment Review Commission and the Prospective Payment Assessment Commission—one that deals with doctors and one that deals with hospitals.

On the physician board, 2 of the 13 members are women, and on the hospital payment panel 1 of 17 members is women. That is the bad news. Hopefully, that will get corrected in the future years.

There will be some discussion as to how each of these benefits should be decided, and I am sure that that will be a matter of discussion in the testimony. I would ask each of you, would you be more comfortable having a yet-to-be-identified board with questionable accountability to anyone decide the benefits, or should we continue in the Congress to be ultimately responsible to the public for the benefits?

Olympia.

Ms. SNOWE. Well, I think that is something I certainly would want to think about very carefully. I would prefer that we make that determination. That would be my initial reaction to that, and make that determination to be sure that we are going to provide the standard benefit package that does not represent a two-tiered system and that everyone has access to the same level of health care in this country, and I think we just have to be flexible.

In responding to the gentleman from Iowa, when we look at the variety of issues involved—and it is not going to be an easy debate, there is no question about it—there is a variety of issues that are going to have to be considered and what should be covered and what should be considered standard and not so standard.

But I do think that is a debate that should occur here in the Congress and the decisions ought to be made, because, as you mentioned, we are ultimately accountable for that, and I would rather not have it submitted to a board to make those ultimate determinations.

Chairman STARK. Ms. Lowey.

Ms. LOWEY. Thank you, Mr. Chairman. I think that is going to be a very important decision that we are all going to have to make, and I am certainly open to further discussion, but my instinct is to leave it to the Congress.

I was particularly pleased, for example, that you mentioned mental health services, because so many women do, unfortunately, require those services. It is so much easier to report a broken kneecap or a broken ankle to whatever entity is put in place, any utilization review panel. I am very concerned about confidentiality issues, when it comes to mental health services, and I know we have discussed this in the caucus and there is a strong, strong base of support in the caucus for mental health services.

I feel comfortable having the Congress debate these issues and I do believe that we should be able, with full input from our con-



stituents and others who have knowledge in these areas, to come to a consensus on a basic package.

What is medically necessary is going to be the difficult part of this process, because, again, you can determine a broken kneecap or broken ankle much more easily than you can mental illness, for example. But I do believe that mental illness should be part of the package and I do hope we can come to a consensus here in the Congress.

Chairman STARK. Thank you. I am sure that we will hear today from every provider we have scheduled as to how spending more on their particular service or product will save the whole country money.

Now, there is a prize for the provider who answers Mr. Grandy's question and says that we ought not to pay them anything, because they really do not provide a very useful service or product. I do not know what that prize will be, but when they answer your question that way, they go up in our estimation. [Laughter.]

The two witnesses may leave at their convenience, but we would like to hear from the Honorable Louise Slaughter, who is the chair of the Task Force on Women's Health, who has joined us. Would you like to add to the record this morning, Louise? Welcome to the committee.

**STATEMENT OF HON. LOUISE M. SLAUGHTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK, AND CHAIR, TASK FORCE ON WOMEN'S HEALTH, CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES**

Ms. SLAUGHTER. Thank you very much, Mr. Chairman.

I apologize for getting here late. I was in another meeting.

If I understood your last question, you were saying should the Congress really be involved in making determinations. If it had not been for congressional action, the Office of Research on Women's Health and studies of women's health would not exist. They had not existed years in the past here. Women, as you know, were systematically excluded from all testing at NIH, and they just hoped for the best for us.

But now that we have discovered that and we know that a vast number of women in this country work and pay taxes and help to fund that research, we think it is only fair that we be beneficiaries of it. So I think that is one avenue where congressional action really made a major difference.

I want to thank you for convening this important meeting. I want to testify on the importance of including the full spectrum of women's health services, especially preventive and primary care, which is something else we have always neglected, and I think that has to be a part of what we would consider a comprehensive benefit package.

Most preventive and primary health services are low-cost, low-tech and highly effective. More importantly, these efforts save lives and dollars. Comprehensive benefits for all men, women, and children are the fundamental building blocks of a sound health care system. Without these benefits, the impact of a newly reformed health care system will be marginal, and the health and well-being of all Americans will continue to be in jeopardy.



Historically, health insurance plans were designed as a benefit for male employees in companies. Unfortunately, the women and children in the families of these male employees were regarded as dependents and, therefore, their health care needs were distinct from and even outside of the scope of the initial benefits packages. In addition, a "medically necessary" standard, which was derived for use in the Medicare system and adopted by almost all of the health care reform bills in the 102d Congress, excludes from coverage "items and services \* \* \* which are not reasonable and necessary for the diagnosis and treatment of illness or injury." This standard leaves out fundamental preventive services like maternity care and family planning services, which by definition are not "medically necessary." Now is the perfect time to challenge the practices that have failed us in the past and create an integrated health care system that considers the vital needs of all Americans. As Members of Congress, we have a responsibility to ensure that women's health needs are considered fundamental, not "outside the scope of" a comprehensive benefits package.

Our health care system and the language it uses has largely excluded women. However, our health care system has failed us all—men, women and children alike—otherwise we would not be here today. By failing to guarantee our access to preventive health services, our current system has allowed the death toll for breast cancer to rise steadily from 37,000 in 1984 to more than 50,000 in 1992. By failing to provide life-saving vaccines to adults and children, our current system has allowed the incidence of rubella to increase fivefold since 1987. And over the past 3 years we have sent 54,000 Americans to the hospital with measles, watching more than 100 of those adults and children die from what is an entirely preventable disease.

Until we ensure coverage for a full range of primary and preventive reproductive health care—including family planning services, contraceptives, and abortion—our current health care system can do nothing to reduce the appallingly high rates of teenage pregnancy, infant mortality, and babies born drug-addicted or infected with HIV, all of which ultimately impose costly burdens on not only our health care system, but also on our schools, our housing programs, our criminal justice system, and the national economy in general.

National health care reform is one of the most difficult and complicated issues which we will address, but, essentially, the current debate comes down to compassion versus cost-savings. One side argues that health care is a right and that quality-of-life considerations must be the guiding force of reform. The other side insists that controlling runaway health costs is our only and primary objective. I submit to you, Mr. Chairman, that both objectives can be achieved through a commitment to preventive health.

If we can successfully shift the primary mission of health care away from curing sickness to maintaining wellness, we will simultaneously realize both a dramatic increase in quality of life and a significant savings in health care expenditures. It costs only \$5 to \$10 for a flu shot, but for every senior citizen hospitalized with flu-related conditions, Medicare will willingly pay up to \$10,000 or more for treatment, but will not pay the \$5 to \$10 for the shot.

Our experience with breast cancer provides an even more compelling example. A mammogram is a simple x-ray which costs under \$100 per screening, and a cancerous breast tumor detected by mammography costs as little as \$14,000 to treat. Without the \$100 investment, obviously, we are going to be paying more and more of the \$14,000. But if you really want to consider it down to money terms and take it away from compassion, that is a very compelling point. The treatment costs for advanced-stage breast cancer can soar to an average of \$84,000 per patient. That is a 600-percent increase, all because the opportunity for early detection was missed.

We have both the knowledge and the technology for prevention and early detection and it is unforgivable that we have not yet been completely successful in transferring what we have learned in the lab to what we practice in the doctor's office.

Mr. Chairman, as the Congress and the administration work together to fashion a national health care strategy, we must work to maximize the return on our investments in biomedical research and our expenditures on health care, by including a full array of primary and preventive care services in any basic package of health care benefits. Even though we cannot undo history, we can design an inclusive and accountable health care system for ourselves, our children and our children's children.

I appreciate the opportunity to testify here today and I look forward to working with you.

Chairman STARK. Thank you very much.

Would any of the members like to inquire further?

[No response.]

I want to thank the witnesses.

Ms. SLAUGHTER. Thank you.

Chairman STARK. We look forward to trying, as we work on this package, to see that your concerns are attended to, because Mrs. Johnson is not going to let us do otherwise.

[Laughter.]

Ms. SLAUGHTER. It is good to know that.

Chairman STARK. Thank you very much for helping us this morning. We appreciate it very much.

We will now hear from Michael B. Jones, a partner and actuary of Hewitt Associates, who is accompanied by Dale Yamamoto, who is a consultant and chief health care actuary, and also accompanied by Frank McArdle, a partner and manager of the Washington research office.

Gentlemen I will let you argue among yourselves as to how you are going to proceed. I hope you can summarize your testimony for the committee. Your company is known as a consulting firm with expertise in the design of employee benefit programs and, as with all witnesses, your testimony and full statement will appear in the record.

Mr. Jones, I have you as the lead witness, why don't you start in.



**STATEMENT OF MICHAEL B. JONES, PARTNER AND ACTUARY,  
HEWITT ASSOCIATES, ACCOMPANIED BY DALE YAMAMOTO,  
CONSULTANT AND CHIEF HEALTH CARE ACTUARY; AND  
FRANK McARDLE, PARTNER AND MANAGER, WASHINGTON  
RESEARCH OFFICE**

Mr. JONES. Thank you, Mr. Chairman.

You introduced our firm and you introduced us very nicely, so I do not have to go through that part of what we had planned to say.

We are honored to be here this morning. I think you have an extremely difficult task to try to come up with a standard benefit package. I do not envy your role.

We see our role here this morning not telling you what should be in or out of the package, but, rather, using the data that we have in our long experience in the health care field, to give you our general observations on how employer plans are structured so that perhaps you can take those structures into consideration in your deliberations.

Our data base is probably the most extensive in the country in terms of health care and employee benefit plans. We have data that is updated annually on the plans for salaried employees of 1,000 corporations, mainly the larger corporations in this country. The companies in our data base offer health care coverage to 20 million employees and another estimated 35 million dependents and spouses. So it is a very big piece of the country's health care plans.

From our data, we have seen that there are tremendous differences by region, by group covered and by industry, and we will be sharing some of that data with you. It is shown in even greater detail in the written testimony.

I would like to make one point before we move into the corporate employee-employer health plans. The Medicare system that you are familiar with has developed along different lines than the employer plans. In the 1960s, they were very similar, but differences have evolved.

The indemnity plans cover prescriptions, and Medicare generally does not. The indemnity plans do not cover preventive care directly, and Medicare does to a limited extent, although in the employer plans, some preventive things are coded by the doctors so that they are paid. Medicare covers 100 percent of hospital charges after the deductible, for the first 60 days; physician charges are subject to a separate deductible and copays. Indemnity plans share the cost, but in an indemnity plan, there is usually a single deductible and you have an out-of-pocket limit beyond which the company would pay 100 percent.

With those differences, if you proceed in the direction of designing the standard package along Medicare lines, you will have substantial issues in transition from plans that employees are accustomed to in corporations.

In our written testimony, we have a chart which shows some figures on how HMOs differ from corporate indemnity plans. HMOs generally have richer benefits, generally 100 percent of covered care. HMOs offer quite a bit of preventive care, while the corporate indemnity plans typically do not. Dental plans are typically provided by plans outside the HMOs, so those are pretty similar from



place to place. And the HMO will typically provide lower mental health benefits.

Approximately 78 percent of the companies in our data base offer HMOs. Approximately 20 percent of the employees covered by those companies in our data base have joined the HMOs, so that is not a large number. If, in the direction that health care reform takes, there is going to be some movement toward HMO-like coverage, then I think you have a major transition problem there, also.

Regional variations—I will give you just a couple of examples. If we look at the number of plans providing an up-front deductible of \$100 or less—and that is a low deductible—it's 18 percent of the companies in Connecticut, 50 percent of the companies in Michigan, and it is 31 percent in Wisconsin. You have a tremendous variation there. There are other variations, too, that are outlined in our testimony.

Hourly employee plans generally differ from salaried employee plans. In some circumstances, particularly where there is a strong union, the plans will be the same. In other circumstances, in low-profit industries, for example, the benefits may be less.

As a statistic, 50 percent of the collectively bargained health plans require no employee contribution, versus 20 percent of salaried employee plans. Looking at industry variations on the percentage of companies that do not require any employee contributions to get health care—financial services industry 8 percent, retail 0 percent, defense and aerospace 40 percent, utilities 27 percent—big differences.

These differences lead us to conclude that in trying to fit any standard benefit package into current business practice, you are going to have a lot of trouble with transition, whichever way you do it.

Recently, employers are moving toward more managed care, and in some circumstances, if you look at figure 5 of our written testimony, you will see that we have arrayed different kinds of managed care from high to low on degree of choice by employee, and from low to high in terms of cost control. You will see that the higher the cost control, the lower the freedom of choice by employees.

Another trend we are seeing is giving employees the option of joining HMO-like networks. In some cases, because of the potential need to change doctors if that is done, we will give employees freedom of choice—because they want choice, they have choice now—by allowing them to use their own doctor, but pay a little bit more money. For example, the employer reimburses 90 percent of the cost if they go to one of the network providers versus 70 percent if employees go out of network.

We also need to take into consideration employee attitudes. Medical is by far the most important benefit to employees. Interestingly enough, dental plans rank second to medical. Dental ranks ahead of time off, ahead of pension, ahead of life insurance. An interesting result, which bears out the old saying that logic is an organized way of going wrong with confidence. The dental plans are easier to understand and they are more immediate than the pension, which is very hard to understand, and that is why we think we get that result.

Another employee attitude change is the willingness to change doctors. You will see a chart in our written testimony which has some statistics there. We have asked the employee groups all over the country if they would be willing to change doctors to save significant amounts of money. Where there is a general practitioner involved, 50 percent of employees said they would be willing to change. Where the primary care physician is an obstetrician/gynecologist for females, only 20 percent said that they would be willing to change.

Again, if we go into a system nationally which bases care on an HMO-type delivery system and has some need to force employees to change doctors by virtue of that, it is going to be extremely difficult.

One way to get around that, of course, is to structure some of the incentives that I mentioned before, such that if employees want to buy through the HMO-type structure, they get reimbursed at a certain percent but they may have to pay a little more to go to the doctor that they have been with all along.

There are also other transition arrangements that might be utilized, and some of these really need to be thought through, because I do not think they have been thought through very much. One of those might be requiring a fairly large deductible in early years in the standard plan and phasing into more liberal benefits over time.

This may be done by using a menu approach to planning benefits, where companies can choose among different plans, from high-deductible plans and low-deductible plans. The advantage of that would be that the companies that are not spending a lot of money now could choose the high-deductible plan, still offer some coverage to their employees, but not causing quite the financial problems that might otherwise occur.

The low-deductible plans could be chosen by the employers who are providing pretty good coverage right now. They would then not have the excuse of dropping down to a very low coverage, saving a lot of money and blaming the Government for having done that to people. So the menu approach has some problems to be worked out, but there is some potential there. It just needs to get thought through very carefully.

Chairman STARK. Did you say the menu approach?

Mr. JONES. Yes, giving employers the chance, Mr. Chairman, of having a low- medium- or high-deductible plan.

That is a brief trip through the kinds of information that we wanted to present to you. We have heard the call to the Nation for a larger contribution on the part of private individuals and the private sector in the resolution of our problems. We hope that this information is useful and we are willing to do whatever other analysis might be helpful to the subcommittee.

Thank you.

Chairman STARK. We appreciate that.

[The prepared statement and attachments follow:]

Testimony by  
 Mike Jones  
 Frank McArdle  
 Dale Yamamoto  
 of  
 Hewitt Associates

## Purpose

Mr. Chairman, and Members of the Subcommittee, my name is Mike Jones. I am a consultant with Hewitt Associates and I manage our firm's health benefits consulting activities for the East coast out of our Connecticut office, where I am based. I have been working with employers in the design of their benefit programs for more than 25 years. With me this morning are Dale Yamamoto and Frank McArdle of Hewitt Associates. Dale is our chief health care actuary working out of our national headquarters in Lincolnshire, Illinois. Frank is the manager of our Research office here in Washington.

Hewitt Associates is an international consulting firm specializing in the design, financing, communication, and administration of employee benefit programs. We provide consulting services to over 75 percent of the Fortune 500 and have an active client base of over 2,000 employers.

We are honored to be here this morning. The subject of this hearing is one of the most difficult and important ones you will have to address as part of national health care reform.

Many of the health care reform proposals envision a standardized health care benefit package. Our role this morning is not to tell the Subcommittee what specific benefits should be included or excluded from any standard package but we do have some general observations to share. Our objective is to explain what the typical health benefits are today offered by employers, how those designs may vary in particular regions of the country, and to describe some recent trends that are likely to continue for some years assuming that health care reform is not enacted.

## Historical Perspective

Health care benefits were originally offered by employers to their employees in the early 1900s. They first began as basic protection for when an employee required hospitalization. Coverage was expanded to surgical services in the 1930s and other medical services in the 1940s. Blue Cross and Blue Shield plans became more popular in the 1950s. At that time, the concept of major medical insurance that provided coverage for virtually all health related expenses was born.

When Medicare was enacted in 1965, it was patterned after the benefit structure that was popular at the time. Many employer-provided plans had separate hospital and major medical parts of their total health care plan offering. The plans had little or no copays or deductibles for hospital benefits. The major medical plan typically had deductibles of about \$25 or \$50 and paid 80 percent of the remaining health care costs. And later on, out-of-pocket maximums were added to limit the employee's exposure to cost. Therefore, the split of Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) under Medicare was very natural at that time (although the subsequent development of employer plans has consolidated hospital and medical benefits under the same plan). The major benefits missing in the Medicare package that were typically included in employer plans were prescription drugs and the out-of-pocket maximum.

Until the 1970s, most health care plans were provided through insurance companies. The 1970s also saw many companies change to self-insurance. This movement was accelerated when insurance companies introduced stop loss coverage to help smaller companies protect against unusually bad claim experience during a year.



## The Health Care Plan of Today

Health care plans began to get more complicated in the 1980s. Employers started to realize that the typical family consisting of the husband working and wife at home with two children no longer represented the actual needs of their employees. Employees wanted and demanded more choice in their benefit package so they could select the best combination of benefits for their situation. Thus, the concept of "flexible benefits" was created.

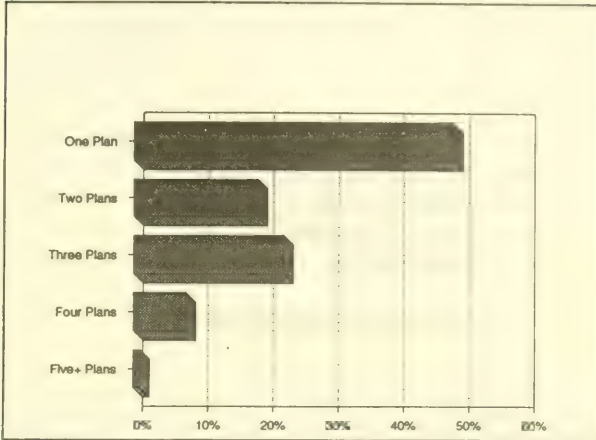
In addition, as health care cost pressures mounted, companies began to alter the level of benefits provided. Typical changes were to apply deductibles and coinsurance to all kinds of expenses, including hospital and surgical.

For the past 20 years, Hewitt Associates has maintained a data base of benefit plan provisions. Currently, we have provisions for the salaried employees of over 1,000 major employers (SpecBook™). In addition, we maintain data on the provisions for the hourly and union employees of more than 200 major companies. These employers provide benefits to more than 20 million employees and 35 million of their spouses and dependents. Many employers in our data base offer their employees a choice of medical plans.

As Figure 1 shows, over half have more than one medical plan in addition to standard HMOs. Where more than one plan is offered, alternative plans could be indemnity plans with higher deductibles and copays, so the employees can choose the coverage that benefits their personal situation. Also, the alternative plan might be PPOs or other managed care options. In addition, 78 percent of the employers offer health maintenance organizations (HMOs).

The *average* medium-sized to large employer will offer its employees at least one indemnity plan choice and one HMO. The typical indemnity plan would look like the following:

- Comprehensive major medical plan design (all services are paid under the plan's provisions);
- Front end deductible of around \$200 per person;
- After the deductible, the plan will pay 80 percent of covered expenses;
- The employee will have his out-of-pocket expenses limited to about \$1,500 (including the deductible) per person; and
- Employee contributions range from \$0- (20 percent of employers) to over \$50 per month for single coverage and from \$0- (12 percent of employers) to over \$150 per month for family coverage.

**Figure 1: Number of plans offered by employers in addition to HMO.**

Another way to state the above is that the plan pays 80 percent of covered expenses from \$200 to \$6,700 and 100 percent of covered expenses above \$6,700.

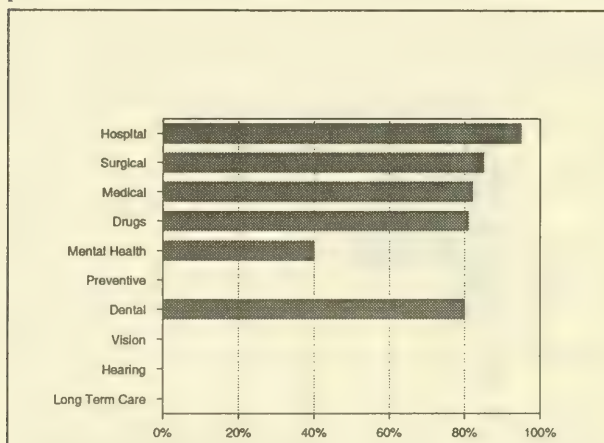
Comprehensive plans will typically cover all medical expenses that are incurred due to injury or illness, as long as the fees charged by providers are not out of line with what other providers charge. This would include hospital stays, physician fees, X-rays and testing, mental health care, and prescription drugs. It would typically exclude preventive care, cosmetic surgery, experimental procedures, and other expenses that were not due to injury or illness. The plans would also exclude expenses that were paid under another plan (e.g., veterans' hospital or workers' compensation).

HMOs generally provide "richer" benefits than indemnity plans and also offer the luxury to the employee of no claims forms for them to file. The typical HMO plan of benefits provides 100 percent coverage of all services except for nominal copays per physician visit (e.g., \$10 per visit). They will cover the same types of services the indemnity plan does and will usually include preventive services. These higher benefit levels are provided because HMOs negotiate discounted fees from providers, restrict employee choice of providers, and may manage delivery of services more efficiently. In general, HMOs provide lower levels of benefits than indemnity plans do for mental health and substance abuse services.

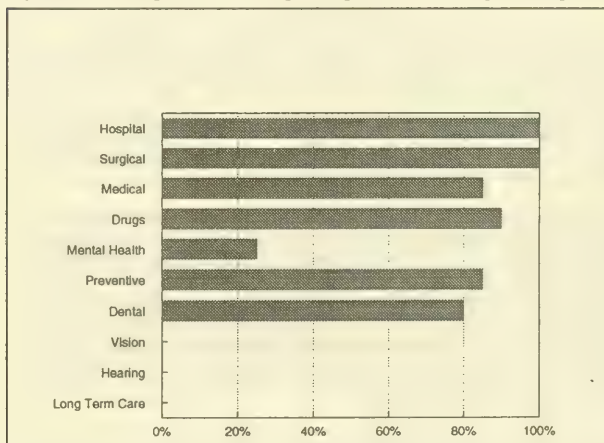
Figures 2 and 3 provide a graphical illustration of the estimated level of benefits provided under the average indemnity plan and average HMO for each major service category of health care costs. Note that neither of the plans typically pay for vision, hearing and long-term care plans. And, they both limit the coverage of mental health and substance abuse costs, but to varying degrees. Usually the employee also gets benefits from a stand-alone dental plan, which is available to HMO and indemnity plan participants alike. Ninety-two percent of our data base employers offer a dental plan. In addition, 32 percent of our data base employers offer a corporate vision care plan, and 9 percent offer hearing care.

The typical coinsurance level for indemnity plans is 80 percent. Figure 2 shows several services being reimbursed at higher rates. The reason for this is that the typical plan will also have an out-of-pocket limit. Therefore, for high cost services (e.g., hospital and surgical), the benefit percentage paid is greater than the 80 percent.

**Figure 2: Percentage of covered expenses paid under typical indemnity plan.**



**Figure 3: Percentage of covered expenses paid under average HMO plan.**



On average, when an employer offers employees a choice between indemnity plan or HMO coverage, about 25 percent join the HMO. Figure 4 shows the percent of employees in our data base who have elected coverage under an HMO option. For example, 22 percent of employers in our data base have 20 to 29 percent of their employees enrolled in HMOs.

### **Regional Variations**

Figure 4 is based on our overall national data base. You would get very different results if you looked at specific geographic areas of the country. These regional variations can be subtle but quite important to recognize. We have referred to some of those differences below, based on where the employer is headquartered.



**Figure 4: HMO participation.**

This table captures the percent of employees who have elected coverage under a standard HMO option. (801 employers)	
Less than 10%	17%
10%–19%	25%
20%–29%	22%
30%–39%	16%
40%–49%	8%
50%–59%	7%
60% or more	5%
	100%

For example, HMOs have had tremendous success in enrolling participants in California and Minnesota. So, you would expect much higher percentage numbers in these two states. In fact, the traditional indemnity medical plan is the primary plan offered by only 19 percent of employers in California but by 75 percent of employers in the Maryland, New Jersey and Pennsylvania areas. 28 percent of employers in California have HMO participation by more than half of their enrollees versus 4 percent of employers in Maryland, New Jersey and Pennsylvania and 2 percent in Texas.

Fifty-two percent of employers in California offer employees a choice among more than two plans (on top of any HMO offering) compared to 33 percent in Wisconsin and 61 percent in Michigan.

Other plan features tend to have geographic differences too. The state of Texas tends to have lower plan limits for mental health and substance abuse care than the average. Also, states that have high health care costs (the Northeast, California, and Florida) tend to have higher plan deductibles and other copay amounts in order to maintain the same level of benefits paid as in other parts of the country. For example, 50 percent of Michigan's large employers have either no deductible or a deductible of \$100 or less compared to 35 percent in California and 21 percent in Texas.

We have attached a table (Attachment A) showing variations in plan design among the states represented by Subcommittee members to give you a flavor for how important regional variations may be.

#### **Hourly vs. Salaried Plan Variations**

As mentioned earlier, the statistics shown in our data base represent the plan provisions of salaried employees' programs. There are generally variations between salaried employees' and hourly employees' benefit programs. In some cases, hourly employees have greater benefits, especially when represented by a union, and in some cases, hourly employees have lesser benefits.

For example, in our Hourly Plans' SpecBook™, we show 50 percent of the collectively bargained plans are provided to employees at no charge. This is in contrast to 20 percent of salaried plans that have no employee contribution.

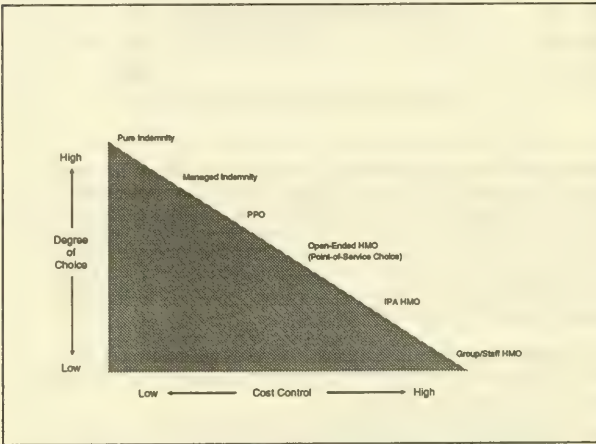
#### **Recent Trends**

During the latter part of the 1980s, employers were subjected to much greater health care cost increases than in previous years. Many employers altered their plans to shift some of their cost increase to employees. These alterations generally took the form of increased deductibles and employee contributions.

In recent years, many have begun to truly understand how costs can be controlled, not by cost shifting, but by identifying and managing factors that underlie the costs. Different elements of these factors are finding their way into today's health care plans.

The general movement of larger employers is to manage both the utilization and the price of health care. Depending on the amount of health care that is "managed" by the plan, the employees' freedom to choose their provider and the type of care they can receive from the plan is limited. Figure 5 graphically shows this tradeoff between employer cost control and employee choice.

Figure 5: Levels of cost control versus employee choice.



Today's indemnity plans typically have many of these "managed" elements included in their plan designs (e.g., utilization review, concurrent review and preadmission testing). These are often called "managed indemnity" plans because the benefits are based on the typical fee-for-service indemnity plan design but have included some managed elements of reviewing health care delivery.

The other types of managed care plans have different benefits depending on whether a person goes to a doctor who has been pre-approved to provide care under the plan (or is in the plan's *network*). "In-network" benefit payments are generally higher than if a non-network provider (hospital or physician) is used. The difference to go to a non-network provider may be to pay a higher deductible (e.g., \$500 non-network versus \$200 in-network) and/or more in coinsurance (e.g., 70 percent non-network versus 90 percent in-network).

A key difference between the "preferred provider" plan and the other three plans shown in the graph (point-of-service, IPA HMO and staff HMO) are that under the latter plans, the covered person must have all services coordinated by a "gatekeeper" that is usually a primary care physician. The gatekeeper may refer the patient to other specialists, but he or she has complete control over the patient's care. In a point-of-service plan, the covered person may go outside the network, but he or she will have to pay higher copays. Generally under HMOs, a person cannot use non-network providers with the exception of limited benefits if they become ill or injured while away from home. Therefore, the HMO has the highest limitations on the employee's choice of health care provider.

### **Glossary—Managed Care Models**

**Pure Indemnity**—Fee-for-service plan with no controls on utilization or price.

**Managed Indemnity**—Fee-for-service plan with utilization review and case management.

**Preferred Provider Organization (PPO)**—A contractual arrangement between providers and an employer or insurance carrier to provide discounted fee-for-service medical care. In most cases, no primary care physician to serve as “gatekeeper.”\*

**Open-Ended HMO (OEHMO/Point-of-Service Choice)**—Arrangement that allows enrollees to make a choice at the point of service either to stay within the HMO network of providers or to receive care (at a higher cost) from non-HMO providers outside of the network. A primary care physician is required and serves as “gatekeeper.”

**Individual Practice Association (IPA) HMO**—A type of HMO that consists of a central administrative authority and a panel of physicians and other providers practicing individually or in small groups in the community.

**Group/Staff Model HMO**—The “traditional” HMO (such as Kaiser) in which physicians work directly for a single HMO. Under a group model, physicians are typically paid via capitation; in a staff model, physicians receive a salary.

Most of the managed care plans (the point-of-service and HMO plans) in place today offer almost 100 percent coverage for all health care services if they are performed within the network. However, recently adopted plans have begun to introduce more copays (plan deductibles, coinsurance and office visit copays) because experience has shown increased use of health services unless the employee has a financial incentive not to use the service.

The two key trends that should be considered in developing a standard benefit package are that employers are moving to managed care types of plans, and higher levels of employee copays and contributions are being introduced. Financial incentives are being created to encourage the use of more cost-effective providers, but the employee usually also retains the option of higher or lower levels of coverage.

### **Other Design Features to Consider**

If the Subcommittee is concerned about the potential costs involved with a standard benefit package, here are some additional design aspects that you may wish to consider.

**A standard benefit package will need to focus on both cost and utilization to achieve overall cost control.**

Hewitt Associates maintains several different data bases to support our health care practice. Based on these data bases, we have helped employers design their benefit program to provide health care services to their employees that meet the employer's objectives in terms of cost and quality. We have learned a lot from this data analysis. For example, we have made comparisons of actual costs and utilization of services against expected results. In one case, we noted that the employer had negotiated very attractive discounts with a group of physicians to be included in a preferred provider network. When their actual experience was analyzed, however, there were *apparent* savings from a price of

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\*Gatekeeper—A primary care physician who is accountable for the total health services of enrollees, arranges referrals, and supervises other care such as specialist services and hospitalization. Gatekeepers are typically used to manage care in HMOs and OEHMOs.



services perspective, but they were more than offset by higher than expected use of services.

To avoid this problem, the standard benefit package could include items to give employees a financial incentive to seek the most cost-effective care. This can be done by applying deductibles and copays to virtually every form of covered care.

**The standard benefit package should encourage employers to continue to expand on health promotion initiatives that will ultimately lower health care costs.**

We can identify lifestyle related claims that could be prevented. For example, for one client we noted that they had a higher than average rate of premature and underweight babies being delivered. This indicated that it would be beneficial to offer incentives for prenatal care for expectant mothers.

**The standard package may need to be phased in on an industry and regional basis.**

As identified earlier, prevalent benefit practices vary by region of the country. In addition, there are substantial variations by industry. For example, retailing typically has lower benefits than manufacturing. Thus, the legislation might allow the standard package to be phased in to allow for necessary transition from existing plans.

### **Employee Attitudes Toward Health Plan Design**

When designing the standard benefit package, key employee attitudes should be considered to gain public acceptance. Medical benefits are very important to employees, and therefore any change will evoke very emotional responses. Also, given a choice, employees have opted for freedom to choose their own physician over all other considerations, including cost, convenience and quality of care. Please refer to the table below from our employee survey consulting.

Would You Change Doctors to Save Money?

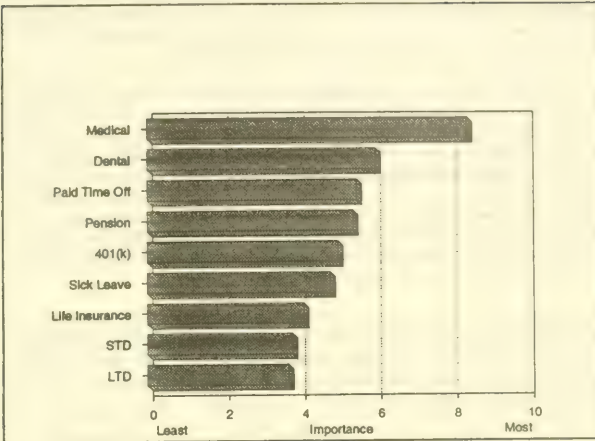
<u>Current Provider</u>	<u>Yes</u>	<u>No</u>	<u>No Response</u>
General Practitioner	50%	39%	11%
OB/GYN*	20%	68%	12%
Pediatrician**	18%	61%	21%
Other Specialist	26%	43%	31%

\* Answered only by females.

\*\* Answered only by those with children.

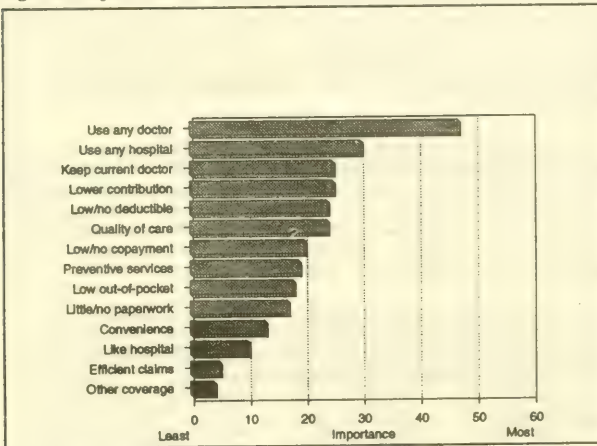
Whenever an employee survey is performed that includes questions on importance of specific benefit programs, medical benefits consistently rank number one. Figure 6 summarizes results of Hewitt Associates' Perception Index™ data base. It clearly shows that medical benefits are the most important employee benefit.

Figure 6: Order of benefit importance to employees.



On another note, when asked why an employee chose a particular medical option, the leading response is the ability to choose any physician. This is over other factors such as cost and convenience. Figure 7 summarizes these responses.

Figure 7: Reported reasons for choosing current medical plan.



Thus, based on the above information, the design of the standard benefit package should consider whether its application will be so restrictive that employees are forced to change their current providers, or should employees be given an option to retain their current providers and pay higher costs?

### Some Observations

There currently is no "standard" health benefit package. There are typical forms of plans offered, but most employees have a significant degree of choice, and they value and appreciate that choice. Therefore, if a single standard health benefit package is imposed on individuals, that would force a wide

variety of human experience down a very narrow funnel. From our experience in designing health care plans, there would be substantial negative employee reaction unless it were preceded by a long and effective educational program to communicate the reasons that there has to be change.

The standard health benefit packages we have seen in proposed legislation make no reference to ancillary benefits such as dental benefits or vision care benefits. Regardless of what priority the Congress assigns to such benefits, the fact is that most employees with major employers now get dental benefits as part of their health plans and that the employees highly value such benefits. If a uniform plan design were to cause them to lose access to those benefits, negative employee reaction would be considerable. Thus, it is important to include the value of health care benefits, other than medical, in determining the "standard benefit package" if that package is to be used for determining the tax deductibility of employer contributions.

Steps also must be taken to *transition* employees to a new form of health benefit plan (e.g., a shift to a standard benefit package) in order to manage change. As mentioned earlier, such a shift could be extremely disruptive of existing provider/patient relationships and therefore provoke strong negative reactions from the public.

Alternatively, transitions toward managed care arrangements can also be accomplished on a phased-in basis, which is sensitive to the existing choices of employees and their families. If done properly, over time and by means of financial incentives, a large majority of employees can end up moving to managed care arrangements. But a sudden shift by government decision-making could be too abrupt and provoke too strong of a backlash.

Imposing a single standard benefit package could well result in a loss of benefits for many employees of the type that these employees highly value. If one of the reasons Congress is looking at a single standard benefit package is to contain costs, it is worth considering that there are many other factors besides standard plan design that may have an equal or greater effect in reducing costs.

For example, in our experience, as much as 40 percent of the costs now incurred by employers and employees may be avoidable costs. We have a data base of approximately 7 million lives that helps us calculate, for each employer and each employee population, where the areas of spending are above the norm and, therefore, where savings can be realized without compromising the quality of care. As examples of these avoidable costs, please refer to the "Data Base Findings on Avoidable Costs" in Attachment B.

If the Committee were to pursue strategies to reduce avoidable costs that would result in savings to the federal government and employers, it may obviate the need to impose a single standard package all at once and reduce the risk of public rejection of the reform concepts.

## **Conclusions**

Mr. Chairman, we hope this information will be of assistance to the Subcommittee as it makes its deliberations.

Like the rest of the Nation, we at Hewitt Associates have heard the call for a larger contribution from private individuals and from the private sector in the resolution of public policy problems. We are prepared to do our part by volunteering our technical assistance as the need arises. Thank you.



**Summary of Plan Provisions**  
Major Employers' Salaried Plans in 1992  
Hewitt Associates' SpeedBook  
(by Headquarters Location of Employer)

**Attachment A**

	General Industry	California	Michigan	Pennsylvania/ New Jersey / Maryland	Louisiana Texas	Washington	Wisconsin	Georgia	Connecticut	Iowa/ Nebraska/ Kansas
	(1,025)	(97)	(36)	(117)	(84)	(13)	(39)	(16)	(33)	(18)
<b>PRESCRIPTION DRUG COVERAGE</b>										
Comprehensive Plan	51%	41%	42%	51%	54%	54%	67%	63%	58%	44%
— with generic incentive	4%	1%		4%	10%	8%	8%	13%	3%	11%
— with mail order incentive	8%	4%	11%	7%	7%	8%	8%		6%	
— with combination of generic and mail order incentives	5%	5%		7%	2%	8%	5%	6%	15%	
Drug Card Plan (100% After Co-Pay)	8%	19%	31%	10%	6%	15%	2%	6%	3%	11%
— with generic incentive	8%	11%	3%	5%	7%		8%			
— with mail order incentive	2%		5%			7%		6%	6%	11%
— with combination of generic and mail order incentives	4%	1%		5%	9%			6%		6%
Depends on medical option selected	10%	17%	8%	11%	5%		2%		3%	17%
Other		1%								
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>DENTAL PLAN PREVALENCE</b>	(1,026)	(96)	(36)	(117)	(84)	(13)	(39)	(16)	(33)	(18)
Have dental plan:										
— based on a percentage of charges	83%	93%	86%	85%	92%	69%	89%	68%	76%	88%
— based on schedule	6%	2%	8%	8%	1%	23%	5%	13%	15%	6%
— based on a combination	3%	1%		3%			3%	6%	6%	
Spending account only	3%	1%	6%	3%	4%	8%		13%		
Depends on plan selected	2%	3%		2%	2%				3%	
No plan	3%			1%		1%	3%			6%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>VISION PLAN PREVALENCE</b>	(1,026)	(97)	(36)	(117)	(84)	(13)	(39)	(16)	(33)	(18)
Have vision plan	32%	58%	39%	28%	35%	77%	54%	37%	27%	28%
Spending account only	42%	24%	47%	45%	32%	8%	28%	38%	55%	50%
Depends on plan selected	1%		3%		1%					
No plan	25%	18%	11%	27%	32%	15%	18%	25%	18%	22%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>HEARING PLAN PREVALENCE</b>	(1,026)	(97)	(36)	(117)	(84)	(13)	(39)	(16)	(33)	(18)
Have hearing plan	9%	11%	22%	9%	11%	23%	8%	12%	9%	11%
Spending account only	49%	40%	47%	51%	37%	23%	38%	44%	58%	50%
Depends on plan selected										
No plan	42%	49%	31%	40%	52%	54%	54%	44%	33%	39%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

**Summary of Plan Provisions**  
Major Employers' Salaried Plans in 1992  
Hewitt Associates' SpecBook  
(by Headquarters Location of Employer)

**Attachment A**

	General Industry	Pennsylvania /					Georgia	Connecticut	Iowa / Nebraska / Kansas
		California	Michigan	Maryland	Louisiana Texas	Washington	Wisconsin		
<b>TYPE OF PLAN</b>									
Traditional Indemnity	(1,026)	(97)	(36)	(117)	(84)	(13)	(39)	(33)	(18)
Indemnity + PPO	57%	19%	64%	75%	51%	69%	72%	76%	28%
Indemnity + POS HMO	9%	18%	17%	6%	10%		5%	6%	16%
PPO	5%	2%	2%	5%	5%			3%	
POS HMO	24%	50%	17%	10%	27%	31%	23%	15%	56%
Other combinations	4%	11%		3%	5%				
Total	1%	100%	100%	100%	100%	100%	100%	100%	100%
<b>HMO PARTICIPATION</b>									
Less than 10%	(801)	(89)	(29)	(107)	(56)	(9)	(23)	(25)	(8)
10% - 19%	17%	4%	14%	26%	23%	11%	5%	15%	13%
20% - 29%	25%	18%	21%	29%	36%	22%	13%	23%	25%
30% - 39%	22%	24%	31%	25%	20%	22%	13%	23%	38%
40% - 49%	16%	18%	17%	9%	16%	45%	26%	23%	
50% - 59%	8%	8%	10%	7%	3%	17%	9%	8%	12%
60% or more	7%	17%	7%	3%	2%		17%	8%	12%
Total	5%	100%	100%	100%	100%	100%	100%	100%	100%
<b>NUMBER OF MEDICAL PLANS</b>									
One Plan	(1,026)	(97)	(36)	(117)	(84)	(13)	(39)	(16)	(18)
Two Plans	49%	48%	39%	46%	54%	62%	67%	49%	44%
Three Plans	19%	20%	22%	16%	15%	15%	20%	15%	11%
Four Plans	23%	24%	25%	27%	19%	23%	10%	12%	28%
Five or More Plans	8%	8%	6%	9%	11%		3%	6%	17%
Total	1%	100%	100%	100%	100%	100%	100%	100%	100%
<b>INDIVIDUAL DEDUCTIBLE</b>									
No Deductible	(1,026)	(97)	(36)	(117)	(84)	(13)	(39)	(33)	(18)
\$100 or less	13%	18%	14%	13%	14%		10%	6%	6%
\$150	14%	17%	36%	13%	8%	38%	21%	12%	11%
\$200	16%	16%	14%	20%	14%	23%	26%	15%	22%
\$250	12%	12%	8%	13%	22%	8%	5%	25%	11%
\$300 or more	11%	11%	8%	14%	6%	8%	2%	12%	22%
Varies by pay	10%	8%					5%	18%	11%
Other	1%								6%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

**Summary of Plan Provisions**  
Major Employers' Salaried Plans in 1992  
Hewitt Associates' SpecBook  
(by Headquarters Location of Employer)

**Attachment A**

General Industry	Pennsylvania/				Louisiana				Iowa/			
	California	Michigan	New Jersey/ Maryland	Texas	Washington	Wisconsin	Georgia	Connecticut	Nebraska/ Kansas			
	(82)	(30)	(102)	(76)	(12)	(34)	(16)	(31)	(18)			
AMOUNT OF STOP LOSS	(907)											
Less than \$500	5%	6%	13%	4%	1%		6%	3%	11%			
\$500	5%	5%	17%	4%			6%	6%	6%			
\$500 - \$999	16%	6%	20%	22%	7%	33%	29%	20%	27%			
\$1,000	21%	22%	20%	15%	24%	17%	32%	25%	13%			
\$1,001 - \$1,999	23%	24%	20%	18%	32%	33%	38%	16%	33%			
\$2,000	7%	16%	8%	13%	8%		6%	10%	6%			
\$2,001 - \$4,999	7%	10%	4%	4%	16%			3%				
\$5,000 or More	1%		1%	1%	1%	3%		29%	11%			
Based on pay	10%	7%	12%	12%	1%	3%						
Family limit only	4%	4%	12%	4%	9%	6%						
Other (e.g., varies by years of service)	1%		1%	1%	1%	3%		1%				
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%			
INPATIENT LIMITS FOR MENTAL HEALTH												
AND CHEMICAL DEPENDENCY	(1,025)											
No special limits	10%	4%	11%	16%	5%	8%	13%	18%	5%			
Limits for both mental health and chemical dependency	78%	88%	78%	70%	69%	77%	56%	67%	78%			
Special limits for mental health only, none for chemical abuse	2%	2%	3%	4%	3%							
Special limits for chemical dependency only, none for mental health	7%	4%	5%	10%	15%	5%	13%	15%	17%			
Other	1%		3%	3%	8%							
Not covered	1%	2%				2%						
Data not available	1%											
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%			
OUTPATIENT LIMITS FOR MENTAL HEALTH												
AND CHEMICAL DEPENDENCY	(1,025)											
No special limits	3%	(97)	(36)	(117)	3%	(13)	(39)	(33)	(18)			
Limits for both mental health and chemical dependency												
Special limits for mental health only, none for chemical abuse	87%	93%	89%	84%	87%	69%	90%	88%	94%			
Special limits for chemical dependency only, none for mental health	5%	1%	8%	8%	6%	3%	6%	12%				
Other	1%			2%	1%				6%			
Not covered	3%	3%	3%	3%	4%	23%	2%	6%				
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%			



## **Attachment B**

### **Hewitt Associates' Data-Based Findings on Avoidable Costs**

In a very general sense, roughly 40 percent of health care costs incurred by an employer may be avoidable. We base this observation on having analyzed the experience of more than 200 major employers in the United States, representing the experience of 7 million individuals.

#### **Provider Price**

Provider price may account for up to 15-20 percent of inappropriate costs. The opportunity to control costs through more aggressive pricing arrangements can be as small as 3 percent or as high as 20 percent. Some carriers' managed care plans and Blue Cross and Blue Shield plans have negotiated very effective payment programs.

We realize that in today's environment, many of these pricing arrangements typically control costs simply by shifting the provider's costs to other payers not covered by such an arrangement. In a future environment where providers are subject to "pricing arrangements" for all payers, the cost savings in this area will have to come from pricing arrangements whereby the provider truly is cutting back on overall cost, instead of only shifting costs.

#### **Utilization**

Inappropriate testing and utilization of services may account for as much as 5-10 percent of the total cost. Price controls alone suggest to us that inappropriate utilization would be exacerbated. Managed care systems that truly track both inpatient and outpatient care by provider should be encouraged.

#### **Lifestyle Management and Early Detection**

Another source of inappropriate cost is tied to lack of early intervention and disease detection, potentially accounting for 5-15 percent of total health care charges. The availability of age-related and clinically supported preventive care benefits will help to reduce the risk of late detection. A primary care system should be considered in which physicians are accountable for managing health as well as illness and for communicating with their patients about the need for, and timing of, periodic exams. We caution, however, that it is not uncommon for 10-15 percent of the eligible work force to forgo their exams even if they are "free." Again, incentives to make employees both care for their own health and seek appropriate medical care should be encouraged.

#### **Administrative Performance**

Administrative inefficiencies can yield up to another 3-5 percent of unnecessary cost for larger employers (and a much higher percent of inappropriate cost for smaller employers). The current health care system supports as many claim forms, claim systems, utilization review approaches, and payment schedules as there are administrators. Simplification, uniformity, and streamlining are essential reform needs. The checks and balances applied to administrators are inadequate. Typically, it is only the larger employers who audit the accuracy and timeliness of their administrators. Smaller employers would benefit dramatically from having a Health Insurance Purchasing Cooperative or other source held accountable for auditing administrators. Just as the National Committee on Quality Assurance (NCQA) reviews processes that measure results and financial solvency ratings, we need a mechanism to ensure quality and accountability in the execution of financial and service transactions.

#### **Employed Spouses**

Coverage for employees' employed spouses who have access to other health insurance also may add more cost for employers:

- Duplicate coverage drains employers of investment and compensation opportunities and the government loses taxable income from both employers and employees.
- Some employers bear the financial burden of being the community source for coverage if they have very low or no contribution for families (or if the employer's plan has more favorable benefit provisions).

If a decision is made to require employers to provide coverage for their own employees and dependents, cost-effective approaches to coordinating duplicate coverage should be addressed as well.

Chairman STARK. Let me see if I understood you correctly. You said your data base indicates that about 20 percent of the employees nationwide join HMOs, and I presume that they all have a choice between an indemnity plan and an HMO.

Mr. JONES. There are a few companies in our data base, and I think it is only one or two, who have gone to a system that says, OK, we are getting out of—

Chairman STARK. HMO or nothing?

Mr. JONES. Yes, "you're going to go to an HMO."

Chairman STARK. But for all practical purposes, isn't it generally less expensive for the company to have their employees select the HMO?

Mr. JONES. That is a difficult question.

Chairman STARK. It is not a good generalization?

Mr. JONES. It is a generalization that is readily accepted by most people, but in our working with employers, that is not necessarily the case.

Chairman STARK. So there would not be subtle pressures on the employee to select the HMO by the employer necessarily in your data base?

Mr. JONES. That is correct.

Chairman STARK. You just said, given free choice, about 20 percent appear to select an HMO, which may differ widely by region, I suspect, but across the country that would be the case?

Mr. JONES. California employers have a very high percentage of HMO participants, and other States have very low.

Chairman STARK. Let me outline, rather than wind through a series of questions here: Let's suppose that we took the Medicare benefit as a base. At some point, we have got to start with a base benefit.

Mr. JONES. Yes.

Chairman STARK. Added first-dollar prenatal and first-dollar child care and put an out-of-pocket cap on it, say, of \$3,000 or whatever is the average for indemnity plans. And then as a way to ease the transition, present much as we do under the Medicare supplemental rules now, a package of not more than three or four benefit options, where the cost might be shared, depending on how we finance this, but, in effect, start with that base plan below which we don't feel we would be willing to go for all citizens, and then have half a dozen options. Then as the years go on, we would see from the choice of those options which seem more popular and cost-effective. How would that strike you or how would you alter that kind of a scenario, if you were going to help us get through this transition, without causing a revolution or causing us to lose an election, and not spend the taxpayers into disaster?

Mr. JONES. I think what you are outlining is something very much akin to the menu approach I was talking about on the indemnity side. I think something like that could work. I think the medigap coverage was designed to get insurance-type products that would be readily designable and underwritten by insurance companies.

If we were to design something, there would be some kind of choices like that. I think we might use as a model more the flexible benefit plan options that we have in corporate America today,



where employees can choose the level of coverage that they want, the level of deductible, much like you can choose in homeowners and auto insurance. We have learned how to underwrite these choices so that the costs do not go through the ceiling. You might get a little more cost sharing between the employee and the provider, also.

Chairman STARK. One popular plan today, I refer to it as the high-altitude plan, would include in the standard benefit package, and I am quoting, only those benefits that have been shown on the basis of outcomes experience to be valuable in promoting the public health and well-being.

In your experience, do you today know which medical benefits covered by employers are cost-effective, or is this something that would take some time to determine?

Mr. JONES. It will take some time to determine.

Chairman STARK. How much, roughly? I mean can you give me a frame of reference?

Mr. JONES. From an actuarial perspective, Dale, how many years of experience would you want to have to be able to do that?

Mr. YAMAMOTO. I am not sure if it is really an actuarial question itself, because you have to focus on a lot of developments that are going on in the medical research area. It is going to be an evolving area.

But, for example, that type of procedure would be useful to provide physicians with guidance that maybe they do not have now. So it will be another tool for their toolbox to provide care.

Mr. JONES. The neat thing about a national health system is that we could put the data controls in effect that would allow us to make those decisions.

Chairman STARK. Mr. McArdle, did you want to comment?

Mr. MCARDLE. I wanted to add, Mr. Chairman, that the outcomes data that we really would like, to be able to do that, isn't available yet. We are getting close to doing that with specific employers, but on a national basis, it is just not there. It is a fascinating theory that you describe, but it is hard to see it actually working at this juncture.

Chairman STARK. Do you think that in 5 years we could develop enough data to begin to make those determinations, sooner or longer?

Mr. JONES. I think 5 years would be a sufficient period.

Mr. MCARDLE. There is a real question, though, about where you want to keep that data, whether you want it at the national level or to leave it at the local level where it is more useful to the health care system.

Chairman STARK. I guess Mr. Grandy is on our list as the first inquirer on your side.

Mr. GRANDY. Thank you, Mr. Chairman.

Gentlemen, I am going to put the same question to you I put to our Members of Congress: How should we go about deciding the basic benefit package? Should it be exclusively the province of Congress and the appropriate committees? Given the obvious political intensity that will entail with that debate, should there be a panel that should be held apart from Congress similar to a Federal Re-

serve Board, that would advise, or should there be some combination thereof? What is your best thought on this?

Mr. JONES. I do not think there is inherently one of those two solutions that is better or worse, from an outsider's point of view, I mean outside the beltway.

Mr. GRANDY. Well, given the data that you have provided and the clear indication from your survey is that, obviously, people want choice, and any kind of prescription of benefits is going to limit choice. And if you follow that graph, obviously, the closer you get to pure indemnity, which I suppose is the ultimate choice, the more expensive the package becomes. The more expensive the package becomes, the more cost containment drives the debate, the more we are subject to political pressures to exclude and delete.

Let me just put one thought in your mind as something that has just occurred to me recently. Would the model that we are currently using to close military bases around the country, whereby a separate panel under the advice of the Department of Defense and various other military and security advisers, presents a list, the commission holds hearings, adds and subtracts from that list, and then presents it as a package to Congress for an up or down vote, with no amendments made in order, would something like that work, in your view, as a way to ultimately decide what at least in the immediate future might be the sanctified benefit package that we would underwrite under a new health care reform package?

Mr. MCARDLE. I think the impact would be very different. There are about 140 million people now who have employer provided coverage. So on a scale, the base closing number of people involved versus 140 million people is a huge difference.

Getting back to your original question, I think there is reason to believe that you could combine both approaches as Congress used in developing RBRVS. They used a research sort of focus in the beginning and then converted that to statute, and maybe that is the appropriate model here.

Mr. GRANDY. The problem with the RBRVS, though, is it fell sway to the budget debate and was combined with the 1990 Budget Act and what was supposed to be an attempt to shift behavior modification from specialized care to more general practices wound up becoming a way to just cut services, and that was particularly harmful to rural areas such as the one I represent.

I am just throwing this out, gentlemen, because I think this is a question that is going to be one of the toughest things for us to decide, and not something that I personally think we are going to get done between now and December, which is when the President's timetable kicks in.

Let me ask you one more thing: In your consultations with employers, have you had any data on, for want of a better term, the "medisave" accounts kinds of cash benefits that are provided to employees in lieu of first-dollar coverage? Have you got any experience with that, whereby employers might provide a certain account from which their employees would draw down for some of their first-dollar coverages as a possible way to contain costs?

Mr. JONES. There have been a few employers who have done that. I am not recognizing the name "medisave," but—



Mr. GRANDY. Well, that is a term that surfaced in the last Congress. I do not know who came up with that. But is it a medical IRA or a first-dollar coverage account which is basically the employee's to use or not use. In some situations, it is rolled into a tax-deferred instrument, if they don't spend the dollars over time, and it is portable, it would travel with the employee. I am just curious to know if you have any experience with that as a possible cost savings device.

Mr. MCARDLE. No, there is no experience, because as you know, there would have to be a change in tax law in order to let you roll those sums over from one year to the next. Under current tax law, you have to use them all in one year.

Mr. GRANDY. That would be a change in section 125, is it not? I think Mr. Jacobs had a bill to that effect, and he is a member of this committee.

Mr. MCARDLE. So until you get a change in tax law like that, you really would not see much experimentation like that.

Mr. GRANDY. But is it conceivable that if you did create from a defined benefit to a defined contribution some of the first-dollar expenses, do you give the consumer more power and, in a sense, more responsibility to limit their health expenditures? Is that a wise way to go, based on your breadth of experience?

Mr. JONES. I think that some companies are experimenting with creating accounts like that without the deferral feature, because of the tax problem.

Mr. GRANDY. Just forget about the deferral matter for a minute. Let's just talk about the relative efficacy of it being a health care account, without any tax benefits downstream.

Mr. JONES. I think a couple of companies are experimenting with that. There is another section 125 kind of account which is very, very prevalent, which the employee puts his or her own money in, but that is a different deal.

Mr. GRANDY. But I was really talking about something that the employer would actually give to the employee. What I am hearing you say is you have nothing really substantive in terms of data to say whether or not this really saves or does not.

Mr. JONES. That is correct.

Mr. GRANDY. Thank you.

Mr. JONES. Thank you.

Mr. GRANDY. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Grandy.

Mr. Jones, in the Chairman's handout, he indicates that you represent a consulting firm with expertise in the design of employee benefit programs. That being true, where is your basic plan?

Mr. JONES. What is our basic plan?

Mr. KLECZKA. I thought we would see a recommendation for a basic plan.

Mr. JONES. Our charge that we were given was to share the data with the subcommittee that we have. Certainly, we would be more than willing to work to come up with something if asked to do so.

Mr. KLECZKA. In the few short moments that I have, could you possibly share with the committee what you would envision as something akin to a basic plan?



Mr. JONES. I think one of your first decisions is whether you base it on a Medicare model, an indemnity model like a corporation has, or on an HMO kind of a model. You have three very different models that you have to decide between, so I think the first thing is not what goes into it, but what model are you going to use. I think your subcommittee is probably as experienced in dealing with Medicare as anybody around, so I wouldn't purport to tell you how to use that model.

Mr. KLECZKA. In the various managed competition plans that have been introduced thus far, CBO indicates to us that, standing alone, the managed competition concept doesn't save us any dollars. Naturally, with the gigantic expenditure we see on an annual basis and rapidly rising costs, it is incumbent upon us to try to squeeze something out of the current system basically through cost controls. What are your views on cost controls in the early years of any national health care reform of long-term?

Mr. MCARDLE. Well, we think there is a lot of room for saving money in the area of avoidable costs, and in our testimony we have an attachment B where we go through some of those features. Dale can tell you about them in more detail. Basically, with an individual employer, we find as much as 40 percent of that employer's cost may be avoidable, but the prescription is going to vary from one employer to the next.

Mr. KLECZKA. Give me an example or two of the excess costs that could be avoided.

Mr. JONES. Provider price, the providers may be charging more than they should by the market. Overutilization, your employees may be utilizing more than they should because there are no constraints in utilization.

Mr. KLECZKA. Now, where do you find the overutilization? Do you find that in plans where there is no copay or deductible?

Mr. JONES. The research studies that have been done certainly would support the fact that you will have better, lower utilization where you have copays and deductibles and coinsurance.

Mr. KLECZKA. So if it is free, the employee or the user doesn't really have that much of a concern, unless we start taking something out of the pocket?

Mr. JONES. That is what the Rand Corp. studies concluded.

Mr. KLECZKA. I was surprised that the dental came out that high as far as employee benefits. Is it not true that providing dental benefits is a very, very expensive type of a program, especially for young families with children?

Mr. JONES. It is expensive. And I think you have some people who can talk more about dental costs coming on later. But the costs of dental plans are nowhere near the cost of your medical plan, for example.

Another statistic on dental is that 92 percent of the employers in our data base provide dental plans for their salaried employees, a very high prevalence.

Mr. KLECZKA. Do 92 percent of the employers provide the dental plan for salaried employees and not for hourly employees?

Mr. JONES. Our data base mainly covers salaried employees. We do have a smaller data base for hourly, but I don't remember the number on dental plans off the top of my head.

Mr. KLECZKA. Would you recommend that the dental benefit part of the basic health care plan?

Mr. JONES. That is one I have gone both ways on. I think it may not be necessary to have it in the required basic package. But where an employer provides it, if the standard package is to be the basis of counting the tax deductibility, then the employer's contribution to the dental plan should be added to the deductible amount.

Mr. KLECZKA. Congressman Grandy had an interesting set of questions relative to who should set the actual parameters of the basic package. Our experience in Wisconsin, when it comes to Medicaid, is that the States were afforded various options that they could adopt if they so desired. Wisconsin, a very progressive State, adopted them all, and we are in a situation like many other States where the Medicaid program today and the State costs associated with it are driving the State budget, and so I think it is incumbent that we look at a couple of models to the basic plans, possibly a health board or some other type of entity other than ourselves, knowing full well that the pressures to bear on the Members of Congress will be to include everyone. At that point, "basic" means the full range of services, in fact, the entire range of services is something I think we should all be concerned about.

Thank you very much.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

The more I listen to your testimony, the more apparent it is to me, and this is a conclusion I have been gradually coming to in my own mind, that the basic benefit plan will not save money by defining what is in and what is out. You cannot have a health plan without mental health benefits. You certainly cannot have a health plan without drug treatment benefits.

Now, there may be some cosmetic surgical procedures and other things that we can define out, but the issue of cost control is going to depend far more on our ability to eliminate overuse and inappropriate use. So starting from that assumption, Mr. McArdle, you felt that 40 percent of the current costs were avoidable. I think it would be useful for us to go through that. In going through that, I am particularly interested in whether you see any difference in terms of cost control between those companies that are good at profiling practice patterns and those that have incentives for people to participate either in HMOs or some of the IPOs that are now as cost-effective as HMOs. There is a kind of group there that I wouldn't want to call all HMOs, but they are pretty tight networks, they have a good ability to look at appropriateness of care and they are far more cost-effective than very loosely knit IPOs.

Then the third issue that interests me, we have got profiling, we have got intensity of network, and the third thing is individual responsibility. Do you see any variation among plans that, for instance, reward employees who participate in wellness programs or who keep their weight down and their physical fitness up, and that kind of thing? Nonsmoking is a simplistic example of premium variation. In looking at cost control, I am interested in those three elements, but I am interested more in your experience, because it is more concrete.



Mr. MCARDLE. You started out with the question of profiling. In our data base we have about 7 million lives and one thing that this data base permits us to do is to compare an employer's experience against the norms—the norms being the actual medical practices that we see in that locality. One way we help an employer save cost is match their experience up against those norms, and you will find in certain areas the employer is doing very well, yet in other areas the employer may not be doing so well, so you target your strategy for that purpose.

Mrs. JOHNSON. So is this individual physician profiling, individual hospital profiling?

Mr. MCARDLE. These are norms that are gathered from all the providers and all the hospitals in a given locality.

Mrs. JOHNSON. When you look at the use of that norm then as against the individual profiles?

Mr. MCARDLE. In essence, it is a benchmark. You are using the individual profile up against that.

Mrs. JOHNSON. What percentage of the 40 percent of costs that can be controlled are being controlled through that mechanism?

Mr. YAMAMOTO. It will vary among companies, depending on the types of initiatives they are willing to put forth to limit some of the employees' choice of provider.

Mrs. JOHNSON. Could you just acquaint us with the most effective strategies you see? What do you see companies doing that actually ends up having the biggest impact?

Mr. JONES. I think the most effective strategies are those that first take a look at the underlying data, take the kinds of profiling that you mentioned and that Frank was talking about, and figure out what is wrong with your costs. What are the health problems within your work force? Is there excessive cost because of overutilization? Is it overcharges by various providers? Once you have done that, you can then take a look at your particular work force and target your strategy to tackle the problems that you have. Otherwise, you are using a shotgun approach and taking all kinds of different approaches, some of which are going to work and some of which are not. But the really effective companies are the ones that are looking at the data and going with the data.

Now, some of the things that come out of that are the wellness initiatives that you are talking about, the smoke cessation and the drug abuse and the mammograms and the screenings and the health risk appraisals and a lot of things like that. A lot of what comes out of that is going into some of the more intense HMO-type coverages, where you set up a network of HMOs across the country. But you have to look at the data first to get to which solution is going to really be effective.

Mrs. JOHNSON. It is interesting that in Medicare we haven't yet gotten to that point, although we have tried to get to that point, and we are still trying to control costs through a much more specific oversight of appropriateness of individual office visit, a very costly, very intrusive and a much less cost-effective approach.

When you say that only 20 percent of those in your data base choose HMOs, is that because there is no monetary benefit, that the employers don't encourage it? Because in my recent experience, where employers are changing not necessarily to HMOs, but to



fairly tight-knit organizations, they are educating their people about the costs involved. They have differentiated premium structures and they are getting far more participation than those kinds of figures would suggest you are getting in your plans.

Mr. JONES. It is mainly the freedom of choice that is the major reason why employees do not go into HMOs, because they do not want to be limited to a particular group of providers. I think the problem—

Mrs. JOHNSON. Do you have any data that differentiates choice between HMOs and IPOs? I see my time has run out, so I will not pursue this. But HMOs are very restrictive in terms of provider choice and some of the other forms are not so restrictive, and so I would be interested in pursuing that with you at some other time.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I read your testimony last night. At page 13, you express concern that a large benefit package should be phased in slowly, and I want to know is this concern based on an assumption that the benefit package will be provided under employer mandates? If employers are not directly financing the system, would you still have the same concern? And could you give me the idea why you have to phase in a large benefit package slowly?

Mr. JONES. I think the phasing came because there are so many employers who are not providing a lot of coverage right now, and we were assuming in that, that a standard benefit package would be mandated. Our concern is that you have so many regional variations, industry variations and variations on health care plans to provide the different kinds of employee groups, that to mandate a very rich program right now and mandate a level of employer support could be very harmful.

Mr. MCDERMOTT. Does that take into account the multitiered situation you would set up, as you already have some at a high level and you are phasing in others? Are you looking at the impact of that on the whole system?

Mr. JONES. That is why one of the things that we mentioned was that there is a possibility of going to what you are calling "multitiering," and it could be called a "menu plan" or whatever, where you have one plan that has very low value, high deductible and then various plans around that. That would be a kinder and gentler way of getting there, if you will, but fraught with problems in itself. I mean a lot of details would obviously have to be worked out.

Mr. MCDERMOTT. I think it makes it increasingly complex by doing it that way, rather than just going with a simple benefit package and putting it in.

Mr. JONES. It makes it more complex from a technical point of view, but it probably eases the transition's impact upon employees and employers, and that kind of an approach is not unlike what we have in flexible benefit plans for the majority of large employers in the country today, where employees can choose the level of health care coverage that they want.

Mr. MCDERMOTT. One of the other questions that has occurred to me, as I have looked at this whole question of a benefit package, is the understanding that I have about the managed competition

system, where you will have accountable health plans with benefit packages under the HIPC, but self-insurers will still be able to offer their own plan. If I am correct in that, can you give me an idea of the impact of allowing the major employers to opt out of the basic purchasing cooperative?

Mr. JONES. I think your major employers will still have quite a bit of an incentive to hold down costs. They are going to want to, even if they are self-insured, most of what they are going to be buying through are those accountable health plans under managed competition models anyway. They would be buying through the HIPCs or through the accountable health plans. But they will have an incentive to hold down costs in the same way that they do now. In fact, under a self-insured arrangement, the employers would have much more of an incentive to provide their employees with some of the things that Mrs. Johnson was talking about in terms of the smoking cessation campaigns, health screenings and those kinds of things, because they are rewarded. If they are in a community rated insured system, the rewards are not necessarily there.

Mr. McDERMOTT. Do you see any danger in terms of their ability to use their purchasing power to drive costs down for themselves, where some other accredited health plan might not have that market power?

Mr. McARDLE. I think the danger is in the other direction, that the HIPC would potentially become so large, and if you had all employers buying through the HIPC, that there might not be much competition out there, in fact. So keeping larger employers outside of the HIPC is one way of keeping more competition in the whole system.

Mr. McDERMOTT. So you think it helps the competition by keeping them outside?

Mr. McARDLE. Keeping large employers outside of the HIPC could help the competitive marketplace, yes, because there would be more providers, more AHPs, et cetera. Whereas, if you just had one big HIPC that was doing all the buying, then the number of entities that could survive in that environment would narrow, probably not unlike the airline industry today.

Mr. McDERMOTT. But isn't that the theory of having the HIPC, because you would see an 800-pound gorilla who they will get whatever it wants, and can drive the cost down?

Mr. McARDLE. But the HIPC is also designed for individuals and small employers, and that was the idea, to give these people who now have no leverage, to give them a leverage that is equivalent to what a large employer already has. It wasn't to take everybody and put them in a HIPC.

Mr. McDERMOTT. So you think under managed competition that has always been the design, that they would always leave the large employers out to continue doing their own deal?

Mr. McARDLE. Right, but there is a big definitional problem of who is a larger employer. I have seen some legislation which says 1,000 employees or less, which is a pretty big employer by traditional Government standards, which is usually 100 or less for a small employer or 250 or more for a large employer. So how you draw that line about which size employer gets in a HIPC is a big definitional issue for you.



Mr. McDERMOTT. When you were doing your analysis, did you assume that they would all be operating off the same benefit package, whether they were self-insured or under the HIPC?

Mr. McARDLE. Well, under the legislation that we have seen, they would. There would be a uniform package that would extend to the AHPs and the HIPCs and also to the closed AHP, which it is called, which would be the large employer plan, and a uniform benefit across that whole marketplace.

Mr. McDERMOTT. So if they had more savings in the company plan, let's say, Boeing or PACCAR in my area or some of the big companies, they could then take that money out for profit, rather than put it into other services, as long as they provided the same package as that provided under the purchasing cooperative, no matter what it cost them?

Mr. McARDLE. The legislation could be written in a number of ways, and one way is to give large employers the option of continuing to self-insure and, in effect, to become an AHP, and if that were to happen, yes, you would have those incentives. But you could also write the legislation in the opposite direction.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you.

I apologize for not being here for your testimony, but I would like to ask you some questions about the examples, and a good one is on page 11. In terms of the universe that you surveyed and the conclusions that you draw from the polling that you took, when you say when designing the standard benefit package, key employee attitude should be considered to gain public acceptance, and you have a sliding percentage in terms of the number of people who would not change doctors to save money. These are already people who are predominantly in plans that allow them to make their choice of doctor?

Mr. JONES. Yes.

Mr. THOMAS. What percentage of the total sampled have the ability to choose their own doctor?

Mr. JONES. Virtually all of them do.

Mr. THOMAS. So you are asking a sample to give up something that they have, and do you have any evidence to indicate what a response would be to those who don't have a plan which allows them to choose their own doctor? Or are you asking us to accept these percentages as something roughly to the average American, whether or not they have a plan?

Mr. JONES. The way we are representing these numbers is merely to say that if national health reform developed along the lines where an employee's choice is going to be restricted beyond where it is today, that you are going to have a problem with—

Mr. THOMAS. Of those people who already have plans in which they have a choice of doctor, they are reluctant to give up that portion of the plan?

Mr. JONES. And most employees are in that situation.

Mr. THOMAS. And when you say change doctors to save money, did you have a sliding amount of money that was used to get reactions? Did you have a fixed amount of money, or is that the phrase that was used on the question?



Mr. JONES. We used the word "significant."

Mr. THOMAS. Significant. OK.

Mr. JONES. We obviously would like to have sliced and diced this in a lot of different ways, but within the work we have been doing, we haven't done that.

Mr. THOMAS. My problem is this is one that is going to be held up as evidence, and within the methodological structure that you used, I think it is certainly consistent that where there is a very close personal relationship, especially on the ob/gyn and, obviously, find someone that the kids like and you like, the pediatricians, that there is a higher percentage.

Was there any indication of the number of people in the sample who, when they react to the fact that they would not want to change doctors, have changed doctors in the last year, or any other timeframe as a base for reference? You have been doing this for a long time. Have these percentages remained consistent, and have you ever asked the question, is the doctor that you have now the doctor that you had a year ago, 2 years ago, 5 years ago?

Mr. JONES. We haven't quite constructed the surveys with that level of sophistication. What we are working with here are assignments where we are being paid to do survey work by a particular——

Mr. THOMAS. I understand that.

Mr. JONES. So the limits of the depth they want to know the answer to is the limits to which we go.

Mr. THOMAS. One of the battles we are going to be fighting is self-fulfilling prophecies, and a number of choices need to be made and I am dying to ask the question six different ways than you have asked it, to see what their answer would be, because I think the numbers are less useful to us, given the way in which you have structured it. I am thankful for the numbers, because they are better than no numbers at all.

There clearly is a warning flag there that when you have given someone total freedom of choice and someone else pays for it, and are they unwilling to change, if someone is going to listen to them. I am amazed that 50 percent are willing to give up their general practitioner. That to me is the most significant number here. Half of them are saying yes, pit the guy or lady for more money savings.

So it just depends on how you look at it, and my concern is that these kinds of numbers get nailed up on the wall and I am going to hear it next week, that 68 percent of those folks who have plans in which they get to choose their own doctor will not change doctors, even if they save "a significant amount of money." Then I have got to knock down that, as I look at options available to us with very difficult choices, limited money, and a fundamental need to reform a system which has been causing problems largely because the consumers haven't been educated and understand the full range of options available to them.

So I appreciate the material, but all it does is raise more questions for me than answers. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, on that point, though, would you say that your surveys indicate that even when consumers are educated, a large number want choice of doctor?

Mr. MCARDLE. What we are saying is that the starting point is employees want as much choice as they can have. That doesn't mean they cannot be persuaded or will not want to move. Their willingness to move will depend on a few things. One is their age. Younger employees tend to go into restricted choice more easily. Older and middle-age people are less likely to go into that.

The other is the financial incentives for going and restricting choice, and there can be strong ones, and employees can be encouraged to migrate in one direction or the other. What we were trying to say to the subcommittee is that you cannot make a shift like that, or at least we would not recommend you make such a shift, by fiat or overnight, because the backlash from doing something like that could be considerable.

Mr. LEVIN. Do your surveys give any indication as to how much financial incentive it would take to dramatically shift preference?

Mr. MCARDLE. Well, we can tell you what the standard design is in plans where they are set up. What they will typically do is accommodate as much desire for choice as they can and they will say, "OK, we will set up a new plan and if you get your care through the network, we will pay for 90 percent or more of that care. If you want to go outside of the network to your particular physician, that is fine, but you are going to pay a higher amount for that visit."

Mr. LEVIN. But still a majority choose something other than an HMO or a like entity, right?

Mr. MCARDLE. Right now, 80 percent of the employees in our data base are not in HMOs, and the reason is because of that restriction of choice.

Mr. LEVIN. Do you have any educated guess, from all your surveying work and all the data, what financial incentives would be necessary to bring about a substantial voluntary shift?

Mr. YAMAMOTO. Given the numbers that Frank was giving you of having some kind of incentive in the benefit design of paying at a 90 percent level if you went to a doctor that was in the network versus paying a lower percentage, for example, to 70 percent if they went out of the network, so they had complete freedom of choice, what we have usually seen is that about 80 percent of the employees do select doctors and services provided by the network plan.

Mr. LEVIN. What percentage?

Mr. YAMAMOTO. 80 percent.

Mr. LEVIN. So if you have a 20 percent differential, you get a substantial shift?

Mr. JONES. 20 percent is our rule of thumb that we use for those purposes in working with our clients.

Mr. LEVIN. Is what?

Mr. JONES. Is a rule of thumb that we use, that if you get that spread much lower than 20 percent, then you are treading on a system that really will not achieve the objectives that you want it to.

Mr. LEVIN. A 20 percent differential, how many plans have a 20 percent differential, roughly?

Mr. MCARDLE. Virtually all plans that have a point of service option, which means when you are going to use a specific provider, you go out of network—virtually all of them have a spread between in network and out of network.

Mr. LEVIN. I know that, but how many roughly would have a 20 percent spread?

Mr. MCARDLE. We could check that and supply that to you.

Mr. LEVIN. Would it be a minority?

Mr. MCARDLE. It probably would be——

Mr. LEVIN. Obviously, because it would be a minority—in other words, that kind of a spread is not customary.

Mr. JONES. Oh, I think it would be customary, where you have this point of service choice that we are talking about. In other words, you can choose, when you go to getting the service, to go in network or out of network, and where you have that kind of a choice structured into a corporate plan, that 20 percent spread is pretty common.

Mr. YAMAMOTO. I think we are having a hard time coming up with a number, because it is a moving target. There has been an increase in number of employers that have adopted these point of service types of plans.

Mr. JONES. But we can get the data. If you are interested, we can get the data and give it to you.

[The following was subsequently received:]



## Hewitt Associates

April 2, 1993

The Honorable Sander M. Levin  
Committee on House Ways and Means  
106 Cannon House Office Building  
Washington, DC 20515

Dear Congressman Levin:

At the Ways and Means Health Subcommittee hearing on Tuesday, March 30, you requested, and we promised to provide, data on the number of managed care plans that use a spread of 20% for reimbursements for in-network providers versus out-of-network providers.

Use of managed care plans is a growing trend. In just one year (from 1991 to 1992), the number of managed care plans increased by 7%, and it is projected this trend will continue in the next couple of years as things stand now.

Of the total number of health plans in our database, 34% (283 employers) provide coverage through PPO networks and 9% (90 employers) provide coverage through point-of-service HMOs. The following table shows the prevalence of the reimbursement spreads between in-network and out-of-network benefits.

Spread	POS HMO	PPO
10% and less	6%	38%
15%	4%	5%
20%	6%	42%
25%	3%	4%
30% and more	41%	11%

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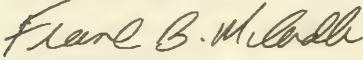
The Honorable Sander M. Levin  
Page 2  
April 2, 1993

Hewitt Associates

Please let us know if we can provide any additional information.

Sincerely,

HEWITT ASSOCIATES

A handwritten signature in cursive script, reading "Frank B. McArdle".

Frank B. McArdle

cc: Charles N. Kahn, Committee on Ways & Means  
Michael Miller, Honorable Sander M. Levin  
Patricia Neuman, Committee on Ways & Means, Subcommittee on Health

Mr. LEVIN. I think it is very relevant. Let me ask you quickly then about the self-insured. Mr. McDermott was pressing you on it, and I think it is a very important and troublesome issue. Leaving the self-insured out of HIPC's may be good for those who are not covered by the self-insureds. The question is what do we do about the substantial number of employers today who are self-insured, insuring large numbers of people? They already have plenty of inducement to contain cost, don't they?

Mr. JONES. Oh, yes.

Mr. LEVIN. And most of them have been undertaking massive or major efforts to control costs, haven't they?

Mr. JONES. That is correct.

Mr. LEVIN. So what help will the new system provide for them? It is a legitimate issue, is it not?

Mr. JONES. In a managed competition environment.

Mr. LEVIN. Well, assume that you adopt what has more or less been discussed as managed competition. How is that going to help the companies and their workers, many of them larger ones that are self-insured? Where are the cost benefits going to come for them?

Mr. JONES. For the ones who are not going to remain self-insured?

Mr. LEVIN. Who remain self-insured. I mean if—

Mr. JONES. If they remain self-insured, they will have the financial incentive to control the costs.

Mr. LEVIN. But they already have that.

Mr. JONES. Right.

Mr. LEVIN. So how are they better off?

Mr. MCARDLE. Well, the legislation includes, as you know, some limits either on employer deductibility or the employee exclusion.

Mr. LEVIN. There is no legislation.

Mr. MCARDLE. No, under some proposed legislation. So that you are saying how do they become more cost-effective if they are self-insured, and under one theory, if they have lower deductible costs and employees had a lower exclusion amount, they would try and become more effective in getting to that amount.

Mr. LEVIN. By taxing the benefits above a certain amount?

Mr. MCARDLE. Under that theory, yes.

Mr. LEVIN. Under that theory, then, what happens is that the workers and the company who are self-insured, who are paying benefits and receiving them beyond the standard benefit, have their taxes increased?

Mr. MCARDLE. That is probably correct, depending on where you draw the line.

Mr. LEVIN. Thank you.

Chairman STARK. I want to thank Mr. Jones and your two associates very much.

We will step out of order for a moment and hear from our colleague, the Honorable Pat Schroeder, from Colorado, who is the chairperson of the Select Committee on Children, Youth, and Families.

Pat, welcome to the committee. I note that you are accompanied by Ms. Judith Jones, director of National Center for Children and Poverty. Your prepared testimony will be included in the record in



its entirety. We would be pleased to have you summarize for us or expand on your prepared testimony any way you are comfortable.

**STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO, CHAIRWOMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES, AND COCHAIR, CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES, ACCOMPANIED BY JUDITH E. JONES, DIRECTOR, NATIONAL CENTER FOR CHILDREN AND POVERTY, AND ASSOCIATE CLINICAL PROFESSOR OF PUBLIC HEALTH, COLUMBIA UNIVERSITY**

Ms. SCHROEDER. Thank you very much, Mr. Chairman.

I must say I come to this committee with a sense of urgency, but knowing your record and the record of many on this committee, I feel a little better. As you know, we are on the eve of the select committee disappearing, and one of the things we wanted to make sure in the select committee that did not happen was that the health care issues only became one of a middle class debate, that we must not forget women and children. So often, they are the last thought of and then we spend all our time scrambling to try and fill those gaps.

Mr. Chairman, as we go out, I would hope that, number one, we could leave hearings—and we will send these around to all the Members—the select committee had very long intensive hearings on health care reform asking how do we deal with women and children and teens. That is part of the reason that I wanted Prof. Judy Jones, who is the director of the National Center on Children and Poverty, to come, because they have just released a new report on health care strategies for children that I think is very important. So if you have questions, she is much more conversant than I am on all the details.

I want to say that when we have had hearings on all of this, we have been very troubled, because as you look at women and children who are not in the middle class, they require services that do not fit in the normal health insurance mode, as we usually think of it. They need some preventive medicine. They need things like immunizations and prenatal care, which very often are not covered in the normal insurance packages that we think about, and I think all of you kind of know that cluster of issues. And I am saying, let's not forget those as they go forward.

The other thing that we found is that teens are a very difficult problem, because even for middle-class teens, we don't know how they fit into the health care problem. Who is the gatekeeper to their health care, how do they get into it, what is teen friendly, what will they use?

And we also know that it is as teenagers, when people get many of the habits, their eating habits, maybe drug habits, sex habits, physical fitness habits, all those things, and actually it is when most of the kids totally fall out of the system.

We have even looked at the one model of Federal health care vis-a-vis teens. We looked at Native Americans who were teenagers who remained in school and found they were not using the Indian health care service, that they did not feel it was teen friendly or they were afraid of the confidentiality problems, and so forth. If the

committee would like to look at that, that is also a very important thing to look at vis-a-vis how teens view their health care and what is transpiring. We also see rising violence among teens becoming a big health care problem, too.

Basically, what I have in my testimony is that the tragedy is: in 1983, when the select committee was formed, we knew that children and teens and women were left out of the process, and here we are 10 years later as we are dissolved, and they are still left out of the process.

We have this big national health care debate going on, and my plea to the committee is let us make sure that whatever is in that health care proposal that we adopt, don't forget these. Now, talking to the Chairman is like talking to the choir; I know that, because we are always coming to him with, whoops, look what we have got to do, look at what we have overlooked. But we want to make sure that that does not happen again.

I also want to say I am encouraged, as I see little things trickle out from the administration. I was very pleased today, for example, to see they were talking about having Medicaid cover the full extension of pregnancy problems from abortion right on through, and I think it is time we grow up about that. So that is a good sign. Let's hope there are more good signs.

We would really like to get this here, because we spent an incredible amount of time looking at that and making sure they are not overlooked once again.

I thank you, and Professor Jones and I would be happy to answer any questions that anyone has about this.

[The prepared statements of Ms. Schroeder and Professor Jones, with attachments, follow:]

**TESTIMONY  
of  
CHAIRWOMAN PATRICIA SCHROEDER  
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES**

**before the  
Subcommittee on Health  
Committee on Ways and Means**

**Tuesday, March 30, 1993  
Washington, D.C.**

Chairman Stark and Members of the Subcommittee:

Mr. Chairman, tomorrow the Select Committee on Children, Youth, and Families goes out of business. When the Committee organized in 1983, every indicator of child health, from infant mortality to childhood immunization, warned that the health status of the nation's children was in jeopardy.

Today, the health care system is no more responsive than it was ten years ago. Nearly 12 million children and teens have no health insurance, and millions more have inadequate coverage. But the Select Committee's work is ended, and it is up to you to take action.

Under your leadership, Mr. Chairman, children's issues have always been given the attention they deserve, but I understand that I might be the only representative at this hearing to discuss the needs of children in health care reform.

It is fortuitous then, that I have accompanying me, Ms. Judy Jones, Associate Clinical Professor of Public Health and Director of the National Center for Children in Poverty in New York. Her organization just released a very important report, "Caring Prescriptions: Comprehensive Health Care Strategies for Young Children in Poverty" that is central to the issues we are talking about today -- how to assure access to quality comprehensive health care for young children from poor families. She is here to answer any questions you may have about what health benefits poor children need and how they can and should be structured at the local level.

As the debate on health care reform progresses under your leadership, and the leadership of the Administration's Health Care Reform Task Force, my fear is that women, children, and especially teens will get lost in the shuffle. Last year, the Select Committee on Children, Youth, and Families began an exploration of the special problems of women, children and teens in gaining access to health care. The goal was to ensure that any health care policy that moves forward -- whether it is the Administration's proposal or the compromises that will inevitably ensue -- knocks down the barriers that still keep so many from receiving the care, especially the preventive care, they need.

Financial barriers, including lack of health insurance, are by far the most common and significant reasons that women and children don't get adequate care. Twelve million children and adolescents, and nine million women of childbearing age, have no health insurance, and millions more have inadequate insurance.

There are other barriers keeping children and families out, even when they are trying their hardest to get the best possible care, including services that are unfriendly and often demeaning, inaccessible clinics with overworked staff, a critical shortage of private primary health care providers, a crumbling public health system, and bureaucratic hassles.

This hearing is focusing on benefits. For families with children, the benefits package is perhaps the most crucial component requiring reform. Under the current system, even families with health insurance don't get the basic preventive care they need, because many policies won't cover immunizations or well-child doctor visits, or even maternity care.

- over -



Substance abuse treatment or mental health services for teens are not only in short supply, but private insurance often won't cover those services either. And families struggling to care for children with disabilities or chronic illness at home, are often forced to choose between poverty, institutionalization, or marital break-up because of limitations in their insurance policies.

Add to this maze the growing complexities and social ills that afflict millions of children and teens across the nation. High infant mortality and shockingly low childhood immunization rates warn that the system is in crisis. AIDS, violence, and drug addiction terrorize our youth and add further stress to the current health care system.

No one should have to endure undue hardship just to obtain medical or support services for themselves or their children. Other nations have demonstrated that it doesn't have to be this way.

No pregnant woman in Europe has to ask how or where she will receive prenatal care or who will pay for it. Immunization rates among infants in countries like Botswana and Brazil far surpass what the U.S. has been able to accomplish. And, compared with our friends in Europe, we fall far short of offering families in need support services such as respite care or home visiting.

Experts at the Select Committee hearing on health care reform and the needs of women, children and teens told us that deciding which benefits should be financed under a given health insurance proposal is one of the most contentious issues in health policy -- especially for women and children. Many of the most important services for this group do not fit the standard insurance model and are often educational, social or behavioral, rather than medical.

I have made available for the record copies of the Select Committee hearing record, as well as summaries, that present a more detailed description of the benefits that women, teens and children need, but I just wanted to highlight those I think are most critical.

First are important preventive health services, including prenatal and postpartum care, family planning, comprehensive reproductive services, and childhood immunizations, among others. Next are major medical services that must include mental health and substance abuse treatment services. The special services and supplies for children with special health care needs or especially vulnerable children from poor families must be included, such as home visiting, respite care, early intervention, social work and nutritional services, to name a few.

Services that make the health care site more family friendly should receive paramount attention: services by mid-level practitioners, such as midwives; child care services on site; translation and transportation services; care coordination and counseling.

I am delighted to have had the opportunity today to share with you the vital information compiled by the Select Committee. The Select Committee has done fabulous work on documenting what Congress needs to do to make the system responsive to children and families. We must now act on that information.

Thank you for the opportunity to testify today on behalf of children, teens and women about the health benefits they need to stay well and protect them during times of illness.

~~ONE MEMBER ABSENT--CONFERRED--~~

PATRICIA SCHROEDER, COLORADO  
CHAIRPERSON

GEORGE MILLER, CALIFORNIA  
WILLIAM LINDSAY, FLORIDA  
MATTHEW F. BRADLEY, NEW YORK  
TED WEISS, NEW YORK  
BETTY ANTHONY, ALABAMA  
BARBARA BOXER, CALIFORNIA  
BARBARA M. LIPIN, MICHIGAN  
J. ROY ROWLAND, GEORGIA  
GERRY BLOOM, MINNESOTA  
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JIMMIE H. HAYS, MISSISSIPPI  
JOHN BERRY, MISSISSIPPI  
JIM BROWN, MISSISSIPPI  
DOUGLAS "TUT" PITTMAN, FLORIDA  
ROBERT E. "BOB" CHAMBERLAIN, ALABAMA

~~MEMBERS PRESENT--~~

~~STAFF MEMBERS--~~

JILL S. KAGAN

~~DEPUTY STAFF MEMBERS--~~

TELEPHONE 302 230-7000

## U.S. House of Representatives

SELECT COMMITTEE ON  
CHILDREN, YOUTH, AND FAMILIES  
385 HOUSE OFFICE BUILDING ANNEX 2  
WASHINGTON, DC 20515-8401

~~FRANK R. WEAVER, MISSISSIPPI--~~

~~ABSENT--CONFERRED--~~

J. EDWARD RICHARDS, ALABAMA  
CLYDE C. HOLLOMAN, LOUISIANA  
CURT WELDON, PENNSYLVANIA  
LARRY S. BETH, TEXAS  
JAMES T. WALSH, NEW YORK  
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RICHARD JOHN BARTON, PENNSYLVANIA  
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FRANK D. ROSE, CALIFORNIA  
BILL SARTRETT, MISSISSIPPI

~~MEMBERS PRESENT--~~

~~STAFF MEMBERS--~~

~~DEPUTY STAFF MEMBERS--~~

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### HEARING SUMMARY

#### **"HEALTH CARE REFORM: HOW DO WOMEN, CHILDREN, AND TEENS FARE?"** Washington, D.C., May 5, 1992

The Select Committee on Children, Youth, and Families held a hearing "Health Care Reform: How Do Women, Children, and Teens Fare?" to explore the special problems that women, children, and teens experience in gaining access to health care. Witnesses testified that even families with health insurance do not receive the basic preventive care they need because of inadequacies in their coverage, and other structural and access barriers to health services.

Kathleen Renshaw, Parent, accompanied by Marisa Harvey, Age 8, Encinitas, CA, described how her family was forced into a "sick pool" by their insurance company after her daughter Marisa's surgery for a kidney blockage. The family was forced to drop its insurance after its annual premiums climbed to \$16,000. To maintain health services under California Children's Services, the state health program for children with special health care needs, the Renshaws have turned down salary increases and may have to legally separate to allow Mrs. Renshaw to qualify for insurance as a single parent.

Joan and Mike Weaver, Parents, Lorton, VA, testified that their son, Steven, diagnosed with Juvenile Diabetes, was covered by insurance until the policy expired. Steven was denied further insurance coverage because of his pre-existing condition. The Weavers were forced to give up insurance coverage for their son and pay over \$20,000 in out-of-pocket expenses for their son's medical care. As a result, they have had to forgo their dream of ever owning a home. To obtain the promise of coverage, Mr. Weaver recently switched jobs, with a significant reduction in salary.

Sarah S. Brown, M.P.H., Senior Study Director, National Forum on the Future of Children and Families, Institute of Medicine/National Research Council, Washington, DC, discussed health care reform meeting the needs of children, pregnant women, and teenagers. She described health care reform proposals discussed at workshops held by the National Forum, including "multipayer" (public and private funds) and "single-payer" (public funds only) plans. Forum participants agreed that the health care needs of children and pregnant women will best be served by a policy that attends to this overwhelmingly uninsured segment of society. Highlights of the health care policy goals identified by Forum participants include: ensuring access to health care for all children and pregnant women; emphasizing primary and preventive care in coverage; providing health services by qualified, diverse providers; considering existing government grant programs in maternal health when reforming health care; accommodating the special needs of children and pregnant women through cost management measures; and reducing administrative complexity of the health care system from the perspective of both providers and consumers. According to Brown, since the report was released, a troubling response has been that these are issues to be worked out after the fact, probably through regulations. If such issues are still perceived of as marginal, then "our work is cut out for us all -- to bring these topics up again and again, until they attain the same prominence as those currently on the table."

Richard F. Nelson, M.D., President, Association of Maternal and Child Health Programs (AMCHP): Director, Child Health Specialty Clinics and Associate Professor of Pediatrics, University of Iowa, Iowa City, IA, described the AMCHP principles for developing a health care system to meet the needs of women, children, and teens including universal access to care, public health prevention and promotion, consumer and family involvement in health care policy design, and federal, state, and local health agencies taking active roles in reform. Dr. Nelson stressed that although the major health care reform proposals include coverage for a number of preventive services, they limit, or do not cover support services needed by low income families with special health care needs. Dr. Nelson stated that AMCHP recommends support of current public health programs until further reforms can be developed and implemented. These include the Title V Maternal and Child Health program, programs targeted to specific problems such as immunization and lead poisoning, and programs for underserved areas such as community health centers.

Edmund F. Haislmaier, Health Care Policy Analyst, Heritage Foundation, Washington, DC, discussed the underlying causes of health care problems, and reviewed the Heritage Foundation's consumer choice health reform proposal. He stated that the principal reason why the health care system is in trouble is the current tax treatment of health benefits. According to Haislmaier, because workers are not directly involved in the purchase of health care coverage, they are not motivated to seek out the best value in health care. The Heritage Foundation's proposal gives the consumer direct control over health spending by converting money now spent on employee health benefits into cash wages and providing individuals and families with new tax credits for money spent both on health insurance and on out-of-pocket medical care. All heads of households would be required to purchase a basic, catastrophic health insurance policy covering themselves and their family members. Haislmaier suggested that women and children will benefit because consumer choice will bring about better value health care, better access to care, and new incentives for preventive care.

Robert L. Johnson, M.D., F.A.A.P., Director, Division of Adolescent Medicine, New Jersey Medical School, Newark, NY; and Chair of the Board, The Center for Population Options, Washington, DC, testified that adolescence is poorly understood within the health care system and explained the developmental, biological and psychological changes that occur during the teen years, which require special understanding and attention by health care providers. Highlights of health care barriers for teens include financial access, geographic barriers/failure of programs to be comprehensive, and attitudinal barriers/health care provider inadequacies. Dr. Johnson recommended developing a health consumer profile of the adolescent; attending to the unique developmental and psychosocial issues of children; assuring full confidential access to care; developing user-friendly and flexible health care; and designing comprehensive programs.



**ONE-HUNDRED SECOND CONGRESS****FUTRECH SCHROEDER, COLORADO****CHAIRMAN****GEORGE MILLER, CALIFORNIA****WILLIAM LERMA, FLORIDA****MATTHEW F. MCCONNELL, NEW YORK****TED WIGGLES, NEW YORK****BENNY HATCHER, JR., ALABAMA****BARBARA BOXER, CALIFORNIA****BARTON B. LEVIN, MICHIGAN****J. ROY ROUSLAND, GEORGIA****GERRY BOGGS, MISSOURI****ALAN WINKEL, MISSOURI****MATTHEW G. MARTINEZ, CALIFORNIA****LARRY DAVIS, ILLINOIS****RICHARD J. DURBIN, ILLINOIS****DAVID C. BAKER, COLORADO****BILL SAMPALKA, TEXAS****THE JUDICIAL CONFERENCE****BENJAMIN R. CRANLEY, MISSOURI****JOHN KELLY NEER, MISSOURI****JOE BACCHUS, FLORIDA****DOUGLAS "PETE" PETERSON, FLORIDA****ROBERT E. "BOB" CRANLEY, JR., ALABAMA****STAFF DIRECTOR****JILL S. KAGAN****DEPUTY STAFF DIRECTOR****TELEPHONE 302 334-7000****U.S. House of Representatives****SELECT COMMITTEE ON  
CHILDREN, YOUTH, AND FAMILIES****388 HOUSE OFFICE BUILDING ANNEX 2****WASHINGTON, DC 20515-6401****HEALTH CARE REFORM:****HOW DO WOMEN, CHILDREN, AND TEENS FARE?****FACT SHEET****POWER & HONOR, VERMONT****J. EDWARD HARTLEY, ILLINOIS****CLYDE C. HOLLOWAY, LOUISIANA****CURT WILCOX, PENNSYLVANIA****LAMAR S. BAKER, TEXAS****JAMES T. WALSH, NEW YORK****RONALD E. MACHTLEY, NORTH CAROLINA****BOB MCINTYRE, FLORIDA****SCOTT L. CLARK, VIRGINIA****RICHARD JOHN SANTORUM, PENNSYLVANIA****DAVE CAMP, MICHIGAN****FRANK D. ROSS, CALIFORNIA****BILL SAMPALKA, TEXAS****DANIELLE SHAPIRO****CHIEF OF STAFF****DEPUTY CHIEF OF STAFF****TELEPHONE 302 334-7000****RIISING HEALTH CARE COSTS THREATEN AMERICAN FAMILIES**

- In 1991, the U.S. spent an average of \$6,535 per family for health care expenses, of which families paid two-thirds (66%), and businesses paid the remainder. Between 1980 and 1991, average health payments by families increased by 147%. In 1991, average health care expenses consumed 11.7% of family income, up from 9% in 1980. By the year 2000, health care costs will consume a projected 16.4% of average family income. (Families USA Foundation, 1991)
- During the past decade, the proportion of employers who paid 100% of the annual premium for family coverage declined from 51% to 23%. Between 1980 and 1991, the share of employer-sponsored health insurance premiums paid by employees increased from 18% to 23%. (Congressional Research Service, 1992; Families USA Foundation, 1991)

**MILLIONS OF CHILDREN, TEENS, AND WOMEN LEFT UNINSURED**

- In 1990, an estimated 12.2 million children and youth under 21 had no health care coverage. Almost one-third of Hispanic children and nearly half of African-American children are not covered by private or public health insurance compared with 17% of white children. In 1988, one out of three poor adolescents (ages 10-18) was not covered by Medicaid. (Employee Benefit Research Institute [EBRI], 1992; National Black Child Development Institute, 1991; Delgado, 1991; Office of Technology Assessment [OTA], 1991)
- Two-thirds of children under 18 who lacked health insurance lived in families with incomes above the Federal poverty level. In 1990, two-thirds of uninsured children and teens under age 18 were in families whose head of household was employed year-round and one-fourth were in families where the head of household was insured. Children were most likely to be uninsured if their family head was either working in a business with fewer than 25 employees (27%) or self-employed (24%). (EBRI, 1992)
- One in four women in their childbearing years has no health insurance coverage for maternity care. In 1990, an estimated 433,000 women who delivered babies had no health insurance. (Institute of Medicine [IOM], 1988; National Commission on Children, 1991)

**CURRENT HEALTH CARE/INSURANCE SYSTEM FAILS TO PROTECT CHILDREN AND TEENS**

- In 1991, only 43% of children had been adequately immunized against childhood diseases by age two, according to a survey of children in nine cities. In 1989, only 45% of employment-based, conventional health insurance plans and 62% of preferred provider organizations provided coverage for basic childhood vaccinations. (Cutts, et al. 1992; National Vaccine Advisory Committee, 1991)
- Only one in five children who need mental health treatment and less than one in eight adolescents who need alcohol or other drug abuse treatment receive it. Private insurance plans are more likely to limit coverage for mental health and substance abuse treatment than other physical health problems; a recent survey of corporate benefit decision makers found that more than half predicted restricting or excluding dependent coverage for mental health and drug abuse treatment services. (U.S. Department of Health and Human Services, 1990; National Association of State Alcohol and Drug Abuse Directors, 1990; OTA, 1991)

**CHILDREN AND YOUTH WITH DISABILITIES AND THEIR FAMILIES FACE SPECIAL HARDSHIP**

- In 1988, nearly 20 million children under age 18 were reported to have one or more chronic illnesses. Of this population, an estimated one million children had severe chronic illnesses, and accounted for 19% of physician contacts and 33% of hospital days related to chronic illness. Two-thirds of disabled children have private health insurance, but only three of every five disabled children living in poverty are covered by Medicaid. Overall, nearly one half million disabled children are without any form of health insurance. (Newacheck and Taylor, 1992; Newacheck, 1990)
- Despite the fact that youth with disabilities make almost three times more physician visits annually, and spend 6 to 9 times as many days hospitalized as their nondisabled peers, one of every five disabled young adults (ages 19-24), and one of every seven disabled adolescents (ages 10-18), are uninsured. (Newacheck, 1989; McManus, Newacheck, and Greaney, 1990)
- Children with disabilities are often unable to qualify for private coverage due to pre-existing condition exclusions and waiting periods used by a growing number of employers. In a study of 713 children with

chronic illness, 10% of parents had health insurance which excluded coverage for some or all of the child's care and 20% had medical debt. Half of the children failed to receive preventive or habilitative care. (Maternal and Child Health Policy Research Center, 1992; Birnbaum, Guyot, and Cohen, 1989)---

- In a survey of parents of disabled children, 54% reported dissatisfaction with their medical insurance and 40% reported significant aspects of home care were not covered. Cost savings to Federal, state, and local government resulting from a transition to home care from a hospital or long-term care setting range from \$100,000 to \$170,000 per child annually. (Human Services Research Institute, 1989; McGauley, 1989)

#### **WIDENING OF CHILDLIN AND FAMILIES LACK ACCESS TO BASIC HEALTH CARE**

- In 1990, 43 million Americans lacked access to primary health services due to their economic situation, health status, or geographic proximity to primary care providers. More than three-fourths (78%) of the medically underserved resides in urban areas. However, rural counties were 2.8 times more likely than urban counties to be medically underserved. (National Association of Community Health Centers, 1992)
- Seven million children do not receive routine medical care. Children from low-income families are less likely than other children to receive physical examinations, vision testing, immunizations, and dental care. (National Association of Children's Hospitals and Related Institutions, 1989; Newacheck and Halton, 1988)
- Adolescents ages 10-18 are less likely to utilize private office-based primary care physicians than any other age group, averaging 1.6 visits per person per year. White adolescents made 89.2% of all visits to private office-based physicians, compared with 8.7% by African-American youth and 7.3% by adolescents of Hispanic ethnicity. (OTA, 1991)

#### **UNINSURED RECEIVE LESS HEALTH CARE AND ARE LESS HEALTHY**

- Babies whose parents have no health insurance are 30% more likely to die or be seriously ill at birth, according to a study of more than 100,000 births in the San Francisco Bay area. Among nearly 30,000 sick newborns treated in California hospitals, those without health insurance were discharged from the hospital 2.5 days sooner than insured infants, and received services that cost 28% less. (Braveman, 1989; Braveman, et al., 1991)
- A 1989 survey of 1,066 Massachusetts households found that uninsured children and teens (under age 18) made 50% fewer physician visits per year and were more than 50% less likely to be hospitalized than children who were insured. One in ten residents who lacked health insurance reported not obtaining medical care due to financial reasons, compared with 1% of those with insurance. (Blendon, et al. 1992)
- In 1989, one-fourth of babies born had mothers who did not obtain prenatal care in the critical first trimester. Two-thirds of women without health insurance do not begin prenatal care in the first trimester, compared with one-fifth of privately insured women. (National Center for Health Statistics, 1991; American Academy of Pediatrics, 1989)
- The uninsured are 33% more likely to be in fair or poor health and nearly twice as likely as those with health insurance to lack a regular source of health care. Uninsured persons also have 27% fewer ambulatory visits and a slightly higher rate of medical emergencies. (Freeman and Blendon, 1987; Robert Wood Johnson Foundation, 1987)

#### **HEALTH CARE PROVIDER SHORTAGE LIMITS HEALTH CARE ACCESS**

- Over the past decade, the number of communities facing severe shortages of primary health care practitioners has remained unchanged. More than 33 million Americans live in areas designated by the Federal government as health professional shortage areas. (Robert Wood Johnson Foundation, 1992)
- Between 1978 and 1989, the percentage of pediatricians who accepted Medicaid patients decreased from 85% to 77%. Nearly 40% of pediatricians who accepted any Medicaid patients during 1989 reported limiting their access to care, an increase of 52% since 1978. (Yudkowsky, et al., 1990)
- The majority of adolescents receive their medical care from providers who have not received subspecialty training in adolescent health. There are estimated to be only one adolescent medicine specialist for every 20,500 adolescents and one adolescent psychiatrist for every 5,000 adolescents. (OTA, 1991)
- In 1988, nearly two-thirds (62%) of rural counties reported having no obstetrician and a slightly greater number reported having no pediatrician. (Center on Budget and Policy Priorities, 1991)

#### **NUMEROUS OTHER BARRIERS TO HEALTH CARE IMPEDE ACCESS FOR CHILDREN AND FAMILIES**

- When insurance status and financial factors are held constant and services are accessible, differences between poor and nonpoor families' utilization of health care almost disappear. (Klerman, 1991)
- Among women who received inadequate prenatal care, transportation difficulties were cited by 23% as a barrier to care, while 22% cited fear of doctors, 16% cited lack of child care, 10% reported cultural biases against male providers, and 7% cited inability to arrange time off work. (General Accounting Office, 1987)
- Nonfinancial and nonlegal barriers to health care for adolescents include lack of availability and willingness of physicians to treat adolescents, inconsistencies between adolescents' perceived needs and the care provided by physicians, adolescents' concerns about confidentiality, and physicians' and other health care providers' lack of competence to identify and treat the health problems of teens. (OTA, 1991)

May 5, 1992

## TESTIMONY of

JUDITH E. JONES

DIRECTOR, NATIONAL CENTER FOR CHILDREN IN POVERTY, AND  
ASSOCIATE CLINICAL PROFESSOR OF PUBLIC HEALTH  
COLUMBIA UNIVERSITY

Committee on Ways and Means

Washington, D.C.

## Chairman Stark and Members of the Subcommittee:

My name is Judith E. Jones. I am Director of the National Center for Children in Poverty and Associate Clinical Professor of Public Health at Columbia University. I also serve as a member of the Kaiser Commission on the Future of Medicaid. Thank you for the opportunity to testify today on those issues that go beyond "basic benefits" and focus on those services that are integral to assuring the healthy development and well-being of children.

The National Center for Children in Poverty was established in 1989 at Columbia University's School of Public Health with support from the Ford Foundation and the Carnegie Corporation of New York. The Center's overall goals are to 1) strengthen policies and programs for poor families and their children under the age of six and 2) heighten awareness of the needs and opportunities in early intervention for this age group. To achieve these goals, the Center collects, synthesizes, assesses and actively disseminates information about poor families and young children and about the policies and programs designed to meet their needs. By making information available about promising program interventions in the fields of maternal and child health, early childhood care and education, and integrated community-based services, the Center hopes to influence the planning and implementation of services for poor families and young children that are responsive to their multiple needs and concerns.

One out of every four children in the United States under the age of six lives in poverty. Poor children face a higher likelihood of illness, disability, and injury from birth onward than do children in middle-class families. While national health care reform has the potential to reduce health risks to poor, young children, the removal of financial barriers alone will not assure access to quality child health services.

A health care plan that will serve this nation's most vulnerable children effectively should prevent and reduce the risks that occur due to lack of adequate care. A health care plan should assure poor children the timely, preventive, comprehensive, high quality care that we want for all of our children. Today I would like to describe those approaches that can help accomplish this goal, as well as those needed to break down the barriers that impede progress.

The Center has just issued a report that identifies the strategies that state and local programs are using to provide quality comprehensive health care services to families and children in poor and underserved communities. Attached is a summary of the report, which is entitled *Caring Prescriptions: Comprehensive Health Care Strategies for Young Children in Poverty*. A statement based on the report's conclusions has been endorsed by state and national leaders in child health, including the American Academy of Pediatrics, the Association of Maternal and Child Health Programs, Zero to Three, the Texas State Board and Departments of Health, and the California Department of Health.

I believe that national health care reform will succeed in promoting an equitable system of health care for children and families if the following principles are applied.



**1) A national health plan must incorporate a service package that addresses the multiple health risks experienced by many low-income families and children.**

Local programs serving children and families should be able to provide the following kinds of services routinely as an integral part of a benefit package: assessment of the needs of pregnant women and newborns, often as part of home visits; identification and monitoring of social, mental health, and environmental risks, as frequently as every week if necessary; and parenting education, social services, crisis intervention, and substance abuse treatment. Effective programs also help families with transportation and translation services when needed, and they make nutritional and developmental assessments that include hearing, vision, dental, and lead screenings, and immunizations provided from birth through age three. Sadly, however, even the eleven promising programs described in the Center's new report, *Caring Prescriptions*, cannot deliver all of these services to all families in need.

Current levels of federal and state funding for the professionals and paraprofessionals who provide these comprehensive services are insufficient. Such services require the skills of lay outreach workers and home visitors, health educators, computer experts, case managers, and analysts. Coordinating the services with other community-based programs requires additional time and expertise. Programs that aim to provide comprehensive, community-based care rely heavily on special project grants, a practice that may limit possibilities for program expansion and replication.

**2) The plan must address the structural barriers to quality care faced by low-income families and their children.** Serious obstacles to developing local systems of health care include lack of appropriate physical facilities, primary care health professionals, and administrative/planning entities. Together, they add up to critical levels of "deferred maintenance" for our primary health care infrastructure. I believe that the new monies proposed by the Clinton Administration for repairing bridges and roads should also be used to shore up our crumbling primary health care infrastructure. Fewer than half of local health departments, for example, provide comprehensive primary care services to children due to space and staff limitation. Similarly, the number of federally funded community health centers—about 600—has not been expanded in many years. The continued expansion of the National Health Service Corps and increased financing for community health centers could extend services to many underserved neighborhoods.

Professionals who can deliver primary health care are insufficient. Community health centers find it very difficult to recruit and retain primary care physicians. The numbers of primary care physicians, pediatric nurse practitioners, public health nurses, and nurse-midwives being trained will not meet the demand that will be created if universal health insurance is available. For example, only 25,000 nurse practitioners are currently working in primary care programs. Federal health professional training grants should be expanded to train these and other public health professionals in programs that combine service with applied research and continuing professional education. Some of the eleven programs described in *Caring Prescriptions* have affiliated with university teaching programs in order to expand capacity, create professional incentives for staff, and add training components.

A number of states and communities have attempted to create new service systems for vulnerable and underserved families by promoting collaboration among different service providers, tracking utilization of preventive care, targeting services on infants and children at highest risk, opening school-based clinics, providing case management, conducting outreach, and financing other supportive services such as home visiting and parenting education. Successful use of these approaches depends upon the availability of resources for local planning, coordination, monitoring, applied research, and evaluation.

State maternal and child health programs currently lack the resources to manage and promote the creation of comprehensive local health care service systems, but, appropriately strengthened, they could play a constructive role with technical

assistance from the federal government. The 1989 OBRA amendments specified requirements for Title V to conduct comprehensive needs assessments and planning in states, with the goal of promoting the development of community-based systems of care. If universal health care financing is available, states could use grants and contracts to develop service capacity in underserved areas, develop and test new service models, and supplement and enhance services that are not financed through insurance. Programs like those reviewed for *Caring Prescriptions* should be strengthened and expanded, possibly in new partnership arrangements with other groups of providers.

**3) The plan must encourage the expansion of promising programs that serve poor families with young children.** *Caring Prescriptions*, our new report authored by Karen N. Bell, the Center's Associate Director for Maternal and Child Health, and by Linda S. Simkin, a health care evaluator, describes these and other strategies used by programs that meet a broad definition of quality health care for children—appropriate to their social, developmental, and medical needs. The programs featured in the report deliver services that are accessible, comprehensive, continuous, coordinated, accountable, and community-oriented. Despite the promising results achieved by such programs, they remain limited either in capacity or in scope of services by lack of financing and inability to recruit primary care physicians.

- In Lexington, Kentucky, the Family Care Center provides comprehensive health care services in a specially designed facility that houses adult education and child care. Physicians, social workers and psychologists affiliated with the University of Kentucky provide much of the care, and part of their training encourages them to integrate services in consultation with the family. Facilities like these are valuable not only for the services they provide, but for the teaching role they play. Sadly, this facility is unique in Kentucky, and the professionals being trained here will not encounter many opportunities to replicate such multi-service centers that meet so many family needs.

Health care reform should include incentives and financing for start-up costs associated with constructing new facilities in low-income and medically underserved areas—facilities that house an array of services especially needed by families with infants and young children. These facilities, through connections to universities, can also be training sites for the many new primary care providers who will be needed. Community health centers can be encouraged to develop stronger ties with primary care teaching programs.

- The CHIP Program in Roanoke, Virginia, provides parenting education, social services and health care to low-income infants and young children through a partnership between the county health department, the community action agency, and private medical practitioners. Expansion and replication of the program to other medically underserved areas of Virginia is not easy, however. In many counties there is no appropriate leadership. Funding for the family workers and public health nurses is not available through Medicaid because many low-income families cannot qualify, and state policies do not permit reimbursement for case management, home visits, and parenting education.

Health care reform should promote the expansion, strengthening and replication of programs like CHIP. In the short run family support workers and nurse practitioners can increase the productivity and effectiveness of physicians. In the longer term, however, new physicians and pediatric nurse practitioners will have to be trained and employed by organizations such as CHIP.

- In Dallas, Texas, Parkland Memorial Hospital has taken the leadership to extend primary care into underserved communities. It has developed an attractive group practice arrangement for employing salaried physicians, and has obtained county funding to finance construction of new facilities. Its planning department conducted a version of the national medical care survey locally with the help of VISTA volunteers, to assess medical care needs in greater Dallas. Using the Children and Youth project in West Dallas as a model for services, COPC developed sliding fee scales and

multiple financing arrangements in order to make primary care services available and accessible to low-income families and prevent unnecessary hospitalization.

Health care reform should encourage hospitals to work collaboratively with community-based organizations to make comprehensive primary care services available in low-income neighborhoods. The organizational features of the COPC programs in Dallas are well worth considering for incorporation into national models of local comprehensive primary care systems.

**4) The plan must incorporate mechanisms for quality assurance that are tailored to children.** New standards that govern the content, frequency, intensity, and delivery of services to very low-income children will be needed for any type of managed care arrangements that emerge under health care reform. The multiple risks faced by infants and children living in poverty, and the greater incidence of health problems and the limited resources available to their families, all argue for imposing regulations and developing quality assurance approaches to monitor the care actually received by low-income children.

In summary, we cannot afford to create a de-facto two-class system of care that pretends that the typical 15-minute well-child visit for a middle class child is sufficient to address all of the risks faced by many low-income children. For example, the Pediatric Resource Centers in New York City, which serve a high proportion of high risk infants and children, have set productivity standards of 2,800 encounters annually for a full-time pediatrician, considerably fewer than the federal standard of 4,200 set for community health centers. Yet a "standard" benefit package that does not take differential risk into account would create programs that do not meet the needs of poor families with young children.

Nor can we afford to let "the best" be the enemy of "the good". Regulations that are too strict or that do not allow for a period of gradual growth and expansion in service range and capacity will keep providers out of medically underserved areas. Pediatric nurse practitioners and even lay workers, appropriately supervised, can replace or enhance the services of physicians.

National health care reform will challenge local health care providers to respond by forming new partnerships and possibly changing the content and organization of services. The impact of reform on poor families with young children may be adverse unless change is based on knowledge of strategies that work at the state and local levels, and of the barriers that currently halt the expansion of promising programs—such as administrative complexity, institutional rigidity, lack of infrastructure, an inadequate supply of primary care providers, and lack of funding for supportive services. The eleven state and local programs described in *Caring Prescriptions* collectively illustrate "best practices" for poor and underserved communities. The best features of such programs should inform new efforts to provide health care to poor families. We believe that a truly national health care reform must include incentives that will enable local health care systems to assure access to comprehensive quality services for poor families with young children.



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**SUMMARY OF KEY FINDINGS IN  
 CARING PRESCRIPTIONS:  
 COMPREHENSIVE HEALTH CARE STRATEGIES  
 FOR YOUNG CHILDREN IN POVERTY**

To be successful, health care reform must promote access to quality comprehensive care for young children from low-income families. The National Center for Children in Poverty has published a new report, *Caring Prescriptions: Comprehensive Health Care Strategies for Young Children in Poverty*, which calls for systems of care to be developed and strengthened at the local level, using state and federal support.

The findings are based on a review of eleven selected programs that collectively illustrate "best practices" for vulnerable families with young children. Of the programs reviewed, four are freestanding, four are multisite networks, and three are state programs that reach between one-third and one-half of at-risk infants. Despite differences in organization, all of these programs involve public-private partnerships.

Programs that effectively meet the needs of disadvantaged young children and their families use a variety of strategies to deliver quality services. Program attributes found to be essential are comprehensiveness, continuity, coordination, accountability, and community orientation. Promising programs like those reviewed for *Caring Prescriptions* can constitute the basis for local expanded systems of enriched services provided that leaders at the federal and state level work with local providers to assure universal access, to rebuild the primary health care infrastructure, and to take an active role in planning and monitoring the delivery of care to underserved populations. Such systems will also benefit greatly from financing reforms at the federal and state levels.

Authors Karen N. Bell and Linda S. Simkin note several approaches that communities can adopt to create, strengthen, or expand local systems of care. These include, among others:

- Organize local systems to meet the changing needs of children and families. Community leaders, working with state and local agencies and providers of services to children, can identify problems that are not being addressed or resources that could be better utilized, as well as estimate the number of children that do not have any regular primary care provider. Specialty care and family supportive service providers usually welcome the chance to discuss common concerns in the community.
- Incorporate case management, or care coordination, into ongoing programs. Case management, or care coordination as it is often called by health care providers, helps to assure quality primary care for children living in disadvantaged circumstances by addressing the family's multiple needs and by tracking children to make sure they receive recommended services. It is an integral program component for local health care systems that want to offer a wide range of supplementary services. It also helps those families who have to overcome multiple barriers to obtain care—barriers such as language, transportation, child care, and eligibility.
- Involve hospitals in local systems. Hospitals, functioning as sponsors or partners, are crucial to the success of quality comprehensive care programs—whether the local programs are freestanding or larger systems. In these and other programs, hospital linkages extend the continuum of services through specialty and inpatient care. Medical residents can deliver

primary and preventive care as part of their training, and hospitals can also provide administrative support. In inner cities, some hospital outpatient departments have taken the lead in establishing community-based clinics affiliated with the hospital to deliver primary care.

The new report calls for community groups to work together with public agencies to fulfill a broad vision of health and equity for disadvantaged young children and families. Specific approaches employed by programs to incorporate principles of quality into the systems of care include:

#### *Accessibility*

- Offer services that are convenient for low-income families to use.
- Market primary care services to all community groups.
- Make health care affordable.
- Make Medicaid participation more attractive for providers.
- Reduce structural barriers to access.

#### *Comprehensiveness*

- Make comprehensive health services available through a single entry point.
- Create systems for channeling needed services to high-risk parents and children. Systems should include risk assessment, case management, multidisciplinary teams, and home visiting.
- Enhance the content of support services, including social and mental health services, nutrition services, and parent education, and family support.
- Establish linkages with emergency, inpatient, and subspecialty care providers.

#### *Coordination*

- Offer care coordination as a Medicaid service.
- Promote care coordination as part of "managed care."
- Integrate health, social, and parent support services.

#### *Continuity of Care*

- Ensure that children have a regular source of ongoing care.
- Provide prenatal care and follow-up after birth.
- Ensure that children see the same medical practitioner at each visit.
- Use record-keeping systems that promote continuity.
- Create financing mechanisms that facilitate continuous eligibility.

#### *Accountability*

- Strengthen management information systems.
- Establish quality standards and monitor compliance.
- Set specific objectives regarding staff performance.
- Train and retrain staff.

#### *Community Orientation*

- Determine community needs.
- Market and orient services to the community.
- Assess the impact of the program on the community.

#### *Conclusion*

The challenge to improving local health systems is to create the many public-private partnerships that are needed to identify needs and services and to implement the needed changes. National health care reform may resolve

financial access barriers, but issues will remain concerning administrative complexity, institutional rigidity, duplication of services, lack of infrastructure, an inadequate supply of service providers, and lack of funding for supportive services such as social work, health education, and case management. Reform efforts will need to:

- Assure universal financial access to comprehensive personal health services.
- Simplify and revise administrative procedures to reward efficient, consumer-oriented systems of care.
- Expand health care infrastructures to cover all underserved populations.
- Strengthen public health agency roles in the planning, delivery, and monitoring of health status and services for mothers and children.

The 96-page report will be available in April from the National Center for Children in Poverty, 154 Haven Avenue, New York, NY 10032. The appendices contain case studies of the eleven programs studied.

## PROGRAMS REVIEWED IN CARING PRESCRIPTIONS

### Freestanding Community-based Programs:

These programs usually operate on a limited scale, under the auspices of a single organizational entity or a partnership, typically with few sites for services.

- Jackson-Hinds Comprehensive Health Center, Jackson, Mississippi  
Contact: Dr. Aaron Shirley at 601-362-5321

*One of the oldest federally funded community health centers, Jackson-Hinds excels in community outreach and sets outcome goals for its staff.*

- West Dallas Children and Youth Project, Dallas, Texas  
Contact: Stephen Rosser at 214-637-1861

*Funding from the Maternal and Child Health Bureau helped establish this "project" 23 years ago. Clinics are located next to elementary schools and serve nearly all the children in the neighborhood.*

- Family Care Center, Lexington, Kentucky  
Contact: Dr. Doane Fischer at 606-288-4053

*Multiple programs that integrate services and staffs are housed in the same facility and provide children and their families with adult education, child care, health education, and health care.*

- Brennan's Health Connection, New Haven, Connecticut  
Contact William Quinn at 203-787-6999

*This school-based clinic affiliated with a community health center provides health care to neighborhood infants and toddlers as well as the children in the elementary school.*

### Local Systems or Networks:

These programs usually involve an organizational entity other than the provider of services (public-private partnership) that coordinates services for a geographically defined target group by acting as a financial and administrative broker.

- The Bronx Health Plan, The Bronx, New York  
Contact: Maura Bluestone at 212-733-4747

*Enrollees in this managed care plan receive health care by choosing a group practice or hospital-affiliated health center.*



- Community Oriented Primary Care: A Program of Parkland Memorial Hospital, Dallas, Texas  
Contact: Stephen Rosser at 214-637-1861

*This network of neighborhood clinics and health centers, supported by a county ad valorem tax, recruits physicians for its group practice.*

- Comprehensive Health Investment Project, Roanoke, Virginia  
Contact: Peggy Balla at 703-857-6993

*CHIP is a partnership between independent practitioners, the health department, and the local community action agency.*

- Pediatric Resource Centers, New York, New York  
Contact: Claire Oliver at 212-285-0220

*These enriched service clinics operate with state block grant support administered by the Medical Health Research Corporation, which monitors the quality of care.*

#### State Maternal and Child Health Programs:

These programs administer public health services directly, and/or through contracts and grants, for women, infants, and children, including children with special health needs. They also have planning and monitoring responsibilities under federal Title V legislation.

- Hawaii's Healthy Start-Family Support Services Program  
Contact: Loretta Fuddy at 808-733-9022 or Gail Breakey at 808-944-9000

*This statewide program reaches about half of all newborns, assesses risks, trains lay workers to visit families in their homes, and monitors health care linkages for enrolled children.*

- Mississippi's Perinatal High Risk Management/Infant Services System  
Contact: Elizabeth Shanks at 601-960-7477

*High-risk infants are monitored by nurses, nutritionists, and social workers, using a team approach and home visits, with financing from Medicaid.*

- South Carolina's Comprehensive Health Care System for Infants and Children  
Contact: Marie Meglen at 803-737-4190

*Creative partnerships between the state Medicaid agency, local health department, and private physicians are improving access to preventive health care for young children.*

Chairman STARK. I will just respond quickly as I did to your colleagues who were here earlier on a series of issues that they are concerned about. I think the good news is that in the new administration there are a number of people who are expressing the same concerns that you are about women's issues, about mental health, about children, about services for the impoverished, and I think they are committed to that.

I guess I would ask you this same question that I asked your colleagues. There is some question as to what would be better, and I would ask if you agree with them that the Congress should define and be responsible for continuously modifying the standard benefit package, rather than some new quasi-governmental board assuring that, unfortunately, both the accountability and the cost problems be answered by us. Would you concur with that, or do you think we should duck these issues and—

Ms. SCHROEDER. No, I certainly would, Mr. Chairman, because I think that is where you have the most accountability. If you have a board that is appointed, it is very, very indirect and very, very hard to get to, and this city is filled with commissions and boards that are nameless faceless creatures that do all sorts of things. I think Professor Jones would agree on that, too.

Ms. JONES. Mr. Chairman, I would say that the issue is not whether it is a board or whether it is Congress, but that we not look at the preventive and supportive services that are essential for promoting the health of low-income mothers and children as supplemental to a basic benefit package, but integral to their well-being.

I also serve as a member of the Kaiser Commission on the Future of Medicaid, and I am making the assumption that the Congress will have some hearings on how Medicaid will be folded into a new health reform plan. But it is clear to us from this current report that our Center has published, that there are a number of quality attributes that have to be built into systems of care for poor families and young children. The services such systems provide are not supplemental, and by that I mean very specifically the kinds of things that Medicaid, for example, currently pays for, like case management, transportation, and translation services. If we lose these preventive and supportive services, then rather than making progress, instead, we are falling back one more time.

The programs that we have looked at all integrated these elements of what we would call quality services at the local system level. I urge you and the committee to look at our report entitled, "Caring Prescriptions," which is really inspiring, because people have done these things outside of national health care reform and against all odds in this crazy patchwork we have of funding in America today.

Chairman STARK. Professor, I concur. We have had some experience recently in California trying to privatize Medicaid and turn it over to HMOs, and we find that all we do is enrich the stockholders and deny benefits to people who even at the low price the State was paying for its Medi-Cal program were better off before turning them over to the sharks in the for-profit HMO business. So it is something that we have to do with some caution.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. I will be brief, because we seem to be getting behind more and more.

I am very interested, as we think through Medicaid and how it is going to be integrated into the national health program, that we allow, for example, community health centers to negotiate agreements with hospitals so that they become more accountable health plans. I think we can foster that in a number of ways.

We can foster it by how we subsidize low-income health. We certainly want to give everyone choice, but the community-based nature of our community health centers is really in and of itself a positive force for health and very important to promote.

I do want to just bring up one other issue. One of the big problems in Medicaid is the lack of effort on the part of some Medicaid recipients, not all, but many, to seek care. Now, Connecticut has just passed a requirement that welfare recipients must prove that they have gotten the well-child shots that are due for the next month or at appropriate times. That actually is having quite a favorable effect. First of all, if transportation is the problem, it focuses on it. But immunization is a problem not because the vaccine is not available, but because we cannot get the people to come and get the immunizations. It is not the whole problem, but it is a significant part.

So I think we have to look at the individual responsibility to seek and get appropriate care, as well as the availability of that care.

Ms. JONES. I would like to respond to that. First of all, you should know I am a "Nutmegger." Also, I am from Wilton, Conn., so I know a lot about the service delivery system in Connecticut and the lack thereof.

In fact, one of the things that deeply disturbs me about the issues that we are currently talking about in national health care reform is that nobody is talking about the crumbling physical public health infrastructure. If we had 20 million people seeking care tomorrow, they would encounter "no room in the inn." I would like to urge that we first look closely at the physical health care resources available to Americans who have been kept out of the system except for emergency rooms.

Second, in talking about community health centers, their numbers have stayed static at 600 over the last decade. If we, in fact, want to talk about community health centers as an important community-based infrastructure piece that would link to a number of secondary and tertiary care facilities, we are going to have to expand that in a major way.

I have been talking to a number of my—

Mrs. JOHNSON. In that regard, we might be far better off to do that and offer free care than to go to vouchers and various other ways of subsidizing purchase.

Ms. JONES. But we have to build up the primary health care infrastructure rather quickly, even if we follow the administration's plan of trying to phase in health care in the next 5 years. I have urged that some of the infrastructure dollars that President Clinton proposes to repair our crumbling roads and bridges be set aside for the crumbling health care infrastructure in the United States as well, and I would urge the committee to look into that, because



this funding represents billions of dollars that we have already agreed on.

I want to make one other comment, though, about parents not seeking care for their children in terms of their well-baby checks or immunizations. Again, we have a number of issues that are important to understand. In Bridgeport, Conn., for example, you have a significant Hispanic population that speaks only Spanish. Only recently have materials been available all around the State that are bilingual. People don't necessarily know that these services are available to them.

I have worked for years in a community surrounding the medical school at Columbia, which is a Dominican community, and it was only when we got involved, that we found that the Medicaid application, which at that time was 10 pages long, was available only in English. So I think that parent education and translation issues must also be considered.

You know, it is one thing to say individual responsibility, because it flows easily from our tongue, but when any one of us would be put in that situation where we are confused, we would not know how to obtain health care, we would not know how to use the system because we come from countries that do not have the rich variety of facilities that United States does. In this situation, it becomes very difficult to exercise choice when you really do not have knowledge.

Mr. JOHNSON. I appreciate that.

Chairman STARK. Thank you.

Dr. McDermott.

Mr. McDERMOTT. No questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, in view of the hour, I have none. I just want to say there has been a lot of good work done through the committee in raising the awareness of the public and ourselves to what one would think would not need consciousness raising, and that is the health of children and women who must be two-thirds of the population.

Mr. SCHROEDER. But are the last thought of, for some reason.

Mr. LEVIN. Thank you.

Mr. SCHROEDER. Thank you very much, and thank you for your service on this select committee.

Chairman STARK. Pat, thank you very much for being with us this morning.

Thank you, Professor Jones.

Ms. SCHROEDER. Thank you.

Chairman STARK. We will proceed now with a panel consisting of Dr. William Straub, senior health policy analyst with the Jackson Hole Group; Mary Nell Lehnhard, who is senior vice president of Blue Cross and Blue Shield Association; James F. Doherty, president and chief executive officer, Group Health Association of America; Mary Deckert, assistant vice president for government relations, Employers Health Insurance, Green Bay, representing the Health Insurance Association of America; and Michael B. Snyder, member of the board of directors, of the Association of Private Pension and Welfare Plans and the director, benefits strategy, Eastman Kodak Co.

I thank the panel for their patience and ask that you proceed to summarize and expand on your testimony in the order that your name was called.

Dr. Straub, do you want to lead off?

**STATEMENT OF WILLIAM H. STRAUB, M.D., SENIOR HEALTH  
POLICY ANALYST, JACKSON HOLE GROUP**

Dr. STRAUB. Mr. Chairman, at this critical juncture of our history, when we are about to restructure our health care system, we feel that it is important to break with convention in benefit plan design and take a bold step in moving toward a new paradigm based on standards of care. Conventional benefit plans begin by defining broad categories of services to be provided or excluded, and then applying specific but largely arbitrary limits in cost sharing to control utilization and cost.

"Appropriateness" and "necessary" are largely defined by insurers. Managed care processes, such as utilization review, are interposed between payers and providers, often producing adversarial relationships. While some managed care processes are based on scientific documentation of effectiveness, there has been reluctance to incorporate this data base into the benefit plan design itself.

We believe that benefit plan design should be based on scientifically documented evidence for effectiveness. A rich and growing body of knowledge in the general area of standards of care and practice guidelines provides an opportunity to introduce rationality into the benefit plan design. High-quality standards have been developed by Rand, the Institute of Medicine, the Agency for Health Care Policy and Research and others.

We have chosen standards for hysterectomy and carotid endarterectomy developed by Rand as examples of procedures for which there is scientific evidence to support defining the circumstances under which these procedures are appropriate and should be provided or excluded.

The written testimony that we have provided details the examples of those approaches from Rand.

Why not support sound cost-effective medical practice through defining explicitly in the benefit plan itself what is provided or excluded based on scientific documentation of efficacy? We urge that this new paradigm be introduced now, believing firmly that failure to do so at this critical juncture could result in lock-in of conventional plan design, which is largely an arbitrary and highly political process at this point.

Now is the time to raise benefit plan design to a new level.

Thank you.

[The prepared statement and subsequent submission follow:]

## From Conventional to Future Plan Design

Conventional design of both indemnity and prepaid plans is characterized by broadly defining those services to be excluded or provided while selectively applying cost-sharing and limits in the plan design to control utilization and cost. Managed care processes such as precertification and utilization review are increasingly used to control costs with "appropriate" and "necessary" largely defined by insurers. Standards of care, guidelines, and outcomes data is largely limited to supporting managed care processes. Conventional plan design has not yet incorporated this growing data base into benefit plan design.

The benefit plan of the future ideally will specify only those diagnostic, preventive, and therapeutic interventions that have been shown on the basis of outcomes experience to be of value in promoting the public health and well being. In the process we will be able to specifically identify those interventions which are ineffective, as well as those conditions for which otherwise effective interventions may provide no net benefit. It will be the task of science to identify beneficial services. It will be the task of society to determine which beneficial services to exclude and which to provide. Computers will make it feasible.

There is considerable interest and a growing body of knowledge in the general area of practice guidelines. Many organizations such as medical societies, the Rand Corporation, the Agency for Health Care Policy & Research, the Institute of Medicine, and others have been very active in developing guidelines or practice parameters. The quality of these efforts is highly variable at this time and their utility to date has largely been in utilization review and precertification. Most agree that there is great potential for guidelines to influence physician behavior if made user friendly. There is little agreement on their role in benefit plan design.

We have introduced a guideline approach to coverage in our model plan using hysterectomy and carotid endarterectomy as examples of how this approach might be applied. In the case of hysterectomy, literature review and expert panel served as the basis for excluding from coverage those circumstances in which hysterectomy was deemed "contraindicated" (Figure 1). In the case of carotid endarterectomy a similar approach to determining "appropriate" and then "necessary" applications of this procedure was available. For the sake of simplicity, the examples are reduced to simple "indications" for which coverage of the procedure would be included in the benefit plan (Figure 2). "Exclusions" and "inclusions" are, for all practical purposes, different sides of the same coin. Both approaches represent modifications from RAND Corporation studies that are of high quality. Many other high quality guidelines are available to incorporate into plan design.

The process for developing practice guidelines and applying them to the benefit plan as well as clinical practice would lie within the province of the Health Standard Board (HealSB) in the Jackson Hole model. Separate technology assessment and outcomes management functions of HealSB would provide the objective and subjective data upon which to base sound judgements of effectiveness and appropriateness (Figure 3). In this manner only those technologies, procedures, and practices deemed to provide net benefit to the patient would be recommended to the National Health Board for inclusion in the standard benefit plan. Over time the benefit plan itself would increasingly be comprised of documented effective and appropriate services, gradually replacing the old paradigm of broad statements of covered services with super-imposed cost sharing, limitations of visits, and external utilization review to control costs.

Despite existing reticence to formally incorporate practice guidelines into the benefit plan, we firmly believe that this is one of their most important and useful applications. We further believe that if an effort is not made to do so now it will be increasingly difficult to do so in the future.

- Presented by: William H. Straub, M.D.  
Jackson Hole Group



**Figure 1 Hysterectomy - Excluded Conditions**

**Hysterectomy\*:** Conditions Under Which Deemed Contraindicated (Un-necessary) and Excluded From Coverage:

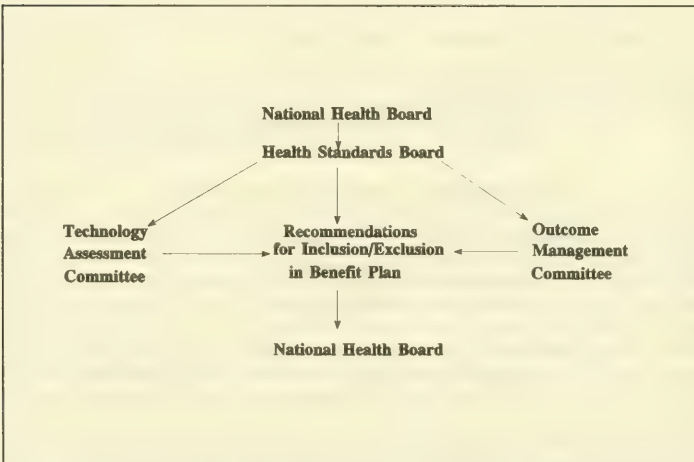
1. Primary Dysmenorrhea if under 24 years old.
2. Endometriosis if:
  - desires to preserve fertility.
  - asymptomatic, under 35 years old.
  - mild diseases.
  - woman less than 24 years old.
3. Adenomyosis if woman less than 24 years old.
4. Abnormal uterine bleeding if:
  - single episode without pathology.
  - adolescents.
  - woman less than 24 years old.
5. Leiomyoma if:
  - desires to preserve fertility.
  - asymptomatic (uterus < 10-12 weeks).
  - woman less than 24 years old.
6. Chronic pelvic pain if woman less than 24 years old.
7. Endometrial hyperplasia if simple cystic hyperplasia.
8. Endometrial polyps if single episode.
9. Cervical dysplasia and carcinoma in sites if woman is less than 24 years old.
10. Cervical carcinoma if stage II or higher.
11. Pelvic cancer if:
  - endometrial cancer stage II or higher.
  - ovarian cancer, desires fertility and Stage IA.
  - nonepithelial, nonmetastatic and less than 35 years old.
12. Pelvic inflammatory disease if desires future fertility.
13. Uterine prolapse if:
  - asymptomatic.
  - mild stress incontinence.
  - woman is less than 24 years old.
14. Asymptomatic if:
  - for sterilization, unless other disease warrants operation.
  - woman is less than 24 years old.
15. Pregnancy catastrophes if:
  - for post-partum hemorrhage if future fertility desired.
  - for dehiscence of scar.
16. Miscellaneous if for:
  - premenstrual tension.
  - chronic cervicitis.
  - useless uterus.
  - single abnormal PAP smear without investigational cause.

\*From RAND, "Hysterectomy, A Literature Review and Ratings of Appropriateness."

**Figure 2 Carotid Endarterectomy - Included Conditions****Included Conditions****Carotid Endarterectomy:****Conditions Under Which Deemed Necessary and Covered:**

- Patients < 80 years old.
- Hemispheric TIA or non-disabling stroke within previous 120 days.
- 70-90% stenosis of the ipsilateral carotid artery or documented ulcerated plaque.

Modified from Hadorn, "Basic Benefits and Clinical Guidelines" and RAND "Carotid Endarterectomy."

**Figure 3 Health Standards Board Functions**

JACKSON HOLE GROUP

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## MEMORANDUM

April 28, 1993

TO: The Honorable Pete Stark  
FROM: William H. Straub, M.D.  
RE: Benefit Plan Cost Estimates

Enclosed please find cost estimates for the "basic" and "standard" benefit plans that were offered in our March 1993 discussion draft (an executive summary is enclosed). Assumptions used are included with the cost estimates which were developed for HMO, POS, PPO, and managed indemnity providers.

Enclosures

Mailing Address: P.O. Box 350 Teton Village, WY 83025  
Fed-Ex/UPS: 6700 North Ellen Creek Road Jackson, WY 83001  
307-739-1176 Fax: 307-739-1177



## On Designing the Initial Uniform Effective Health Benefit Plan (UEHBs)

Prepared by: William H. Straub, M.D.

### EXECUTIVE SUMMARY

#### Background

Managed competition calls for Accountable Health Plans (AHPs) competing to provide a standard set of benefits restricted to appropriate and effective services. While it would be ideal to move from the current largely arbitrary conventional plan design to one based on scientific documentation of efficacy, expediency dictates that a conventional model such as a basic HMO plan be used as the framework for an initial set of UEHBs. We have stressed, however, the importance of introducing scientifically based inclusion or exclusion of covered services as the paradigm for future plan design and selected RAND studies of hysterectomy and carotid endarterectomy as examples.

In order to reconcile the dilemma of providing universal coverage *and* controlling costs we present for consideration the need for a *transitional* "basic" (less costly) benefits plan in addition to a "standard" plan. The goal would be to provide a single standard plan once the provider system (AHPs) had reached near peak efficiency in four to five years. See Table 1 for benefit plan detail, and list of exclusions.

#### Assumptions

- ◆ Cost sharing would be varied between "basic" and "standard" plans.
- ◆ The "basic" plan would have more restrictions on the use, but not the scope of services, than the standard plan.
- ◆ Catastrophic coverage would be assured for all in both plans.
- ◆ Preventive services would be encouraged through both plans.
- ◆ Custodial care would not be provided initially.
- ◆ Prescription drugs would be provided for outpatients.

## MODEL PLAN(s)

**Covered - Copayment or Coinsurance May Apply**  
**Full - No Copayment or Coinsurance is Allowed**

ILLNESS COVERAGE	PLAN A BASIC	PLAN B STANDARD
<i>Acute Care Facility Services:</i>		
Hospital (Acute)	covered - 100 days/year*	covered
Mental Health	30 days*	covered
Substance Abuse	10 days*	covered
*Eligible for extended care after case review		
Emergency Department	covered	covered
Surgicenter	covered	covered
Diagnostic (Lab/X-Ray)	covered	covered
Oncology / Dialysis	covered	covered
<u>Professional Services</u>		
Inpatient Visits (Includes MH & SA)	covered	covered
Office Visits (Includes MH & SA)	covered - 14 visits/year	covered - 28 visits/year
Mental Health (Option)		
Psychotherapy	25% copay/10 visits	covered (50% copay)
Meds Management	10% copay/6 visits	covered (20% copay)
<u>Outpatient Prescription Drugs</u>		
Prescription Drugs	covered - must use generic or formulary if available	covered
<i>Extended Care:</i>		
Speech Therapy	covered - 6 weeks	covered - 8 weeks**
Occupational	covered - 6 weeks	covered - 8 Weeks**
Rehab Services	covered - 6 weeks	covered - 8 weeks**
Nursing Home	covered - 90 days	covered - 180 days
Hospice Care	covered - 14 days	covered
Home Health Services	covered - 20 visits**	covered
Durable Medical Equipment	covered	covered
** Eligible for more, pending case review		

Wellness Promotion	Plan A Basic	Plan B Standard
<i>Preventative / Screening Services: (Guidelines May Apply)***</i>		
Well Baby Visits***	covered	covered
Immunizations***	full	full
Mammography / PAP / Other Approved Screening Studies***	full	full
Vision / Hearing Exams	covered - every 2 years	covered - every 2 years
Pre Natal Visits***	full	full
Physical Exams	covered - every 2 years	covered - every 2 years
<i>AHPs may Elect to Offer Health Education Services Worth up to 10% of Premium.</i>		

#### Exclusions from Coverage

- Eyeglasses or hearing aids
- Preventative and restorative dental services.
- Dental care, except as required secondary to injury.
- Oral Surgery, except for tumor, infection or as required secondary to injury or other medical condition.
- Cosmetic surgery
- Reversal of voluntary sterilization.
- Artificial conception procedures except as approved by plan guidelines (e.g., GIFT or ZIFT for 2 cycles)
- Routine foot care.
- Over the counter drugs.
- Private duty nursing services.
- Custodial care
- Investigational or experimental therapies procedures, or tests except as approved by the Health Standards Board or AHP.
- Specific conditions or circumstances under which the Health Standards Board or AHP determine that otherwise effective treatments have no net benefit.
- Orthodontia

**Guidelines Under Which Specific Conditions or Treatments are Covered or Excluded.** It is the intent of the benefit plan design to incorporate specific exclusions or inclusions of services and/or conditions as well as the specific circumstances under which certain services, technologies, or interventions are considered appropriate and will be covered by the plan. Specific inclusions or exclusions will be based on guidelines developed by various organizations such as the Agency for Health Care Policy and Research, reviewed and recommended by the Health Standards Board (HealSB), and ultimately approved by the NHB for incorporation into the set of UEHBs. Coverage of experimental interventions will be subject to review by the HealSB.

The initial procedures/services to be covered in this fashion are:

- Hysterectomy (see Exhibit No. 2 in UEHB Discussion Draft)
- Carotid Endarterectomy (see Exhibit No. 3 in UEHB Discussion Draft)



**EXHIBIT I**  
**COST SHARING UNDER VARIOUS PLANS**

<b><u>HMO PLANS</u></b>	<b><u>CO-PAYS (IN NETWORK)</u></b>	
<b><u>Service</u></b>	<b><u>Basic - Plan A</u></b>	<b><u>Standard - Plan B</u></b>
Physician Office Visits	\$15	\$10
Hospital/Institutional Care (Inpatient)	\$200 per day Max. 5 days per admission	\$100 per admission
Emergency Department Service (waived if admitted)	\$50	\$25
- Ambulance	\$25	\$25
Limit on Coinsurance		
Individual	\$1500	\$1500
Family	\$3000	\$3000
Prescription Drugs (includes contraceptives)	\$7.50/30 day supply	\$5/30 day supply
Out-Patient Mental/Nervous/ Substance Abuse	50%	50%
<b><u>POS Plans</u></b>		
Coinsurance	80% in network (except inpatient at 100%) 50% out of network	100% in network 70% out of network
Deductible	In-network-hospital Inpatient \$200 per day Max. 5 days per admission Other in-network - none Out of Network - \$300 all expenses	In-network - Hospital Inpatient \$100 per admission Other in-network - none Out of Network - \$300 all expenses
<b><u>Other Services</u></b>		
Physician Office Visits	\$15 in network	\$10 in network
Prescription Drugs (includes (includes contraceptives)	\$7.50/30 day supply	\$5.00/30 day supply
Outpatient Mental/Nervous/ Substance Abuse	50%	50%
Limit on Coinsurance		
Individual	\$2000 in network \$3000 out of network	\$1500 in network \$3000 out of network
Family	\$4000 in network \$6000 in network	\$3000 in network \$6000 out of network

**PPO Plans****Basic - Plan A****Standard - Plan B**

Deductible	\$100 in network \$300 out of network	\$100 in network \$200 out of network
Coinsurance	80% in network 60% out of network	90% in network 70% out of network
Other Services		
Physician Office Visits	\$15 in network	\$10 in network
Prescription Drugs (Includes contraceptives)	\$7.50/30 day supply	\$5 /30 day supply
Outpatient Mental/Nervous/ Substance Abuse	50%	50%
Limit on Coinsurance		
Individual	\$2000 in network \$3000 out of network	\$1500 in network \$3000 out of network
Family	\$4000 in network \$6000 out of network	\$3000 in network \$6000 out of network

**Managed Indemnity Plans****Alternative I**

Deductible (all services)	\$1000
Coinsurance - except maternity	80%
Limit on Coinsurance	
Individual	\$2000
Family	\$4000
Outpatient Mental/Nervous/ Substance Abuse	50%

**Alternative II**

Deductible (all services)	\$250
Coinsurance - except maternity	70%
Limit on Coinsurance	
Individual	\$2000
Family	\$4000
Outpatient Mental/Nervous/ Substance Abuse	50%

NOTE: Under HMO and Managed Indemnity Plans, there is no cost sharing for Maternity Care, either in or out of hospital. Similarly, there is no cost sharing for in-network maternity care, either in or out of hospital, under POS and PPO plans. There is, however, cost sharing for maternity care, both in and out of hospital for non-network maternity care.

**Exhibit II**  
**Per Member Per Month Charges**

	Plan A <u>Basic</u>	Plan B <u>Standard</u>
<b>HMO</b>	\$113.00	\$123.13
<b>POS</b>	\$118.48	\$134.67
<b>PPO</b>	\$124.52	\$135.77
<hr/>		
<b>Managed Indemnity</b>	\$124.33	
	80% coins	
	\$1,000 ded	
	\$2,000 OOP	
	\$125.60	
	70% coins	
	\$250 ded	
	\$2,000 OOP	

- Notes:**
1. All numbers include 10% for expenses, which represents average expenses in a large HMO.
  2. PPO, POS, and HMO numbers reflect typical discounts and utilization management savings across the nation.
  3. In-network utilization assumed to be 90% for both PPO and POS products due to Medicare charge level limitations on out-of-network services.



## Exhibit II

		<u>Plan A</u> <u>Basic</u>	<u>Plan B</u> <u>Standard</u>
HMO	single:	\$124.30	\$135.44
	family:	\$277.38	\$369.39
POS	single:	\$130.32	\$148.14
	family:	\$355.43	\$404.01
PPO	single:	\$136.97	\$149.35
	family:	\$373.55	\$407.31

Managed Indemnity	<u>Basic Plan I</u>		
	single:	\$136.76	80% coins
	Family:	\$372.99	\$1,000 ded
			\$2,000 OOP
	<u>Basic Plan II</u>		
	single:	\$138.16	70% coins
	family:	\$376.81	\$250 ded
			\$2,000 OOP

## Notes:

1. All numbers include 10% for expenses, which represents average expenses in a large HMO.
2. PPO, POS, and HMO numbers reflect typical discounts and utilization management savings across the nation.
3. In-network utilization assumed to be 90% for both PPO and POS products due to Medicare charge level limitations on out-of-network services.

Chairman STARK. Thank you.

Mary Nell, welcome back, and please proceed.

**STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Ms. LEHNHARD. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to testify.

Of course, the first question anyone asks on a topic like this is what benefits should be covered, and we are not here today offering you a list of exactly what services we believe should be covered, but we would make three points about benefit design.

First, we are not sure it is possible to design a single set of benefits that meets the diverse needs of the whole population and, in particular, their financing ability. We believe, even though we know there is tremendous interest in a single benefit package, there may be a need to look at allowing accountable health plans to offer multiple standardized benefit packages. Each of these packages would have to have the basic set of benefits included in it.

Second, and this is obvious, the scope of benefits covered will have a direct effect on consumers' ability to afford coverage. Concern for providing of a broad range of services and benefits must be balanced against the need to keep coverage affordable.

And third, in identifying the covered services, we believe, as you do, it is important to emphasize appropriate preventive services even in the fee-for-service plans. This would help focus our health care system away from treating illness and on keeping people healthy.

In addition to exactly what services are covered, another key element in benefit design is the patient cost sharing, as you have heard this morning. Most people agree that some sort of cost sharing in the form of copayment, coinsurance and deductibles is needed to help keep people conscious of how they are spending money. Of course, this has to be balanced by the concern that unlimited cost sharing could create an affordability barrier, especially for the low-income.

An approach has been suggested by some who get very specific in the legislation about exactly what those cost-sharing levels would look like. However, in being this specific in designing cost-sharing limits, the legislation could perhaps inadvertently define and restrict the types of delivery systems that could be offered. As you have heard this morning, the PPO and point of service products provide incentives for enrollees to use network providers by specifying different levels of cost sharing, whether or not you use the physicians in the network.

A single set of cost-sharing limits would prohibit these types of delivery systems. In an attempt to get specific about the different levels of cost sharing that you would allow for, say, point of service or PPOs isn't the answer, either. None of us know exactly what the most effective levels of cost sharing are that are necessary to direct these patients.

While we oppose strict limits on copayments, coinsurance and deductibles, we believe it would be worth examining whether overall caps of total out-of-pocket expenses would be beneficial.

Finally, a third benefit design issue is the treatment of balance-billing. In fact, protection against balance-billing can be a far more important tool than limits on cost sharing and protecting subscribers and consumers from unexpected and excessive out-of-pocket costs.

The delivery model expected under managed competition, the network model, by definition, has a protection against balance-billing. But the treatment of balance-billing under fee-for-service is the key issue. Fee-for-service plans pay providers on an indemnity basis and don't contract with those providers to prohibit balance-billing, leaving enrollees vulnerable to potentially significant out-of-pocket costs.

While we don't have a recommendation for you today on that, I would mention that most Blue Cross and Blue Shield plans address this issue in their fee-for-service business by establishing contracts with providers that prohibit balance-billing for their enrollees.

Those are the key points in our testimony that we submitted, and we would be pleased to work with the subcommittee on this issue in any way we can.

Thank you.

[The prepared statement follows:]



## TESTIMONY OF

## BLUE CROSS AND BLUE SHIELD ASSOCIATION

## PRESENTED BY

MARY NELL LEHNHARD  
SENIOR VICE PRESIDENT

Mr. Chairman and members of the Committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 71 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for nearly 70 million people. I appreciate the opportunity to testify today on the important issue of the design of a basic benefit package in the context of health care reform.

In my testimony today, I will discuss three key considerations in designing a benefit package: 1) covered benefits and services; 2) patient cost-sharing; and 3) balance billing. Although this last issue is technically a reimbursement issue, it is included here because of its relevance to benefit design. Please note that the testimony assumes broader system reforms are in place that are designed to move the market to more cost-effective, organized delivery systems.

**Covered Benefits and Services**

In the current health care market, benefit design is largely left to employers, working with insurers or health benefits administrators. Employers historically have played a significant role in designing their own benefit packages to meet the specific needs of their employees. This is true not just for large employers, but for small employers as well, although state benefit mandates limit their flexibility in this area.

Many health care reform proposals would take benefit design decisions out of the hands of employers by requiring everyone to be covered by a single set of benefits. Proponents of this approach argue that the current mix of products in the marketplace makes it difficult for consumers to compare coverage between carriers, and that standardization is necessary to enable consumers to make more informed coverage choices.

The Blue Cross and Blue Shield Association believes that there are three guiding principles of benefit package design under health care reform:

1. **Continued Consumer Choice.** The Blue Cross and Blue Shield Association supports giving consumers the information they need to make more informed, more economic coverage decisions. We further support guaranteeing everyone access to a basic level of coverage. However, we do not believe that it is possible to design a single benefit package that meets the very diverse health care needs and financing abilities of our population. To provide continued choice and flexibility for employers and individuals, two approaches could be pursued:
  - a First, allowing carriers to offer multiple, standard benefit packages. Each of the packages would have to include the basic level of coverage guaranteed to everyone; and
  - a Second, allowing carriers to offer benefits that are equivalent in value, but not identical, to a standard benefit package.

Both of these approaches assure consumers would receive the same overall level of coverage but would give them flexibility in choosing the exact mix of benefits they would receive.

**2. Affordability.** While the Association strongly supports broad system reform to address overall health care costs, policymakers need to recognize that the scope of benefits covered also will have a significant effect on consumers' ability to afford coverage. For this reason, the Association believes strongly that in designing the basic benefit packages, concern for providing coverage of a broad range of services and benefits must be balanced against the need to keep coverage affordable.

State mandated benefit laws provide an example of the affordability barriers that can result from too great an emphasis on the scope of coverage. These laws can add considerably to the cost of coverage -- by as much as 20 percent in some states. In addition, state laws that require coverage of particular health care providers, such as allied health professionals, also can add to the cost of coverage. While it may be appropriate for carriers to cover services provided by such groups -- especially in underserved areas -- mandating their inclusion in all cases is likely to exacerbate affordability concerns. As a result, coverage is placed out of reach for many of the consumers affected by these laws -- namely, small employers and individuals.

**3. Appropriate Preventive Services.** Finally, in determining the content of the basic benefit packages, we believe it is important to emphasize coverage of appropriate preventive services. We believe that such an emphasis will help move our health care system away from a focus on treating illness and toward a focus on keeping people healthy.

### Cost-sharing

The second key component of benefit design is patient cost-sharing. Most people agree that some form of cost-sharing -- in the form of co-payments, co-insurance and deductibles -- is needed to encourage more cost-conscious decision-making by consumers. However, this belief is balanced by a concern that unlimited cost-sharing creates affordability barriers, especially for low-income individuals. Some policymakers have responded to this concern by proposing to specify levels of cost-sharing that would be allowed in the basic benefit package.

The Association is concerned that specific cost-sharing limits would, perhaps inadvertently, define and restrict the types of delivery systems carriers could offer. For example, PPOs and Point-of-Service products provide incentives for enrollees to use network providers by establishing different cost-sharing requirements for in-network and out-of-network providers. Cost-sharing limits that were defined too tightly would prohibit further use and development of these types of delivery systems.

Thus, specific cost-sharing limits would undermine a key strategy of managed competition -- to establish incentives for the market to

restructure itself in the most cost-effective ways possible. This approach would stifle the very innovations in delivery system design that are desired, by presuming that we already know what the most cost-effective approaches are.

Another reason for providing flexibility in cost-sharing is to encourage innovation. For example, one very progressive way of establishing cost-sharing requirements is to rely on income-related deductibles. This approach reduces out-of-pocket costs for employees with the least ability to pay. Many employers, including the Blue Cross and Blue Shield Association, are moving in this direction.

While we oppose strict limits on co-payments, coinsurance and deductibles, we believe it would be worth examining whether overall caps on total out-of-pocket payments for consumers would be a feasible alternative approach to assure consumer protection against high out-of-pocket costs.

### **Balance Billing**

The third key issue related to benefit design is the treatment of balance billing -- that is, whether providers are allowed to bill consumers for amounts in excess of their carriers' payment. While balance billing technically is a reimbursement issue, it is relevant to the discussion of benefit design because limits on cost-sharing will not protect consumers from unlimited out-of-pocket costs unless they are coupled with limits on balance billing. In fact, protection against balance billing can be a far more important tool than limits on cost-sharing in protecting consumers from excessive and unexpected out-of-pocket costs.

The primary delivery model envisioned under managed competition -- namely, network models -- by their very nature include contracts with providers that can provide protection against balance billing.

But the treatment of balance billing is relevant in light of policymakers' interest in maintaining a fee-for-service option under a managed competition system. Blue Cross and Blue Shield Plans address this issue in their fee-for-service coverage by establishing contracts with providers to prohibit balance billing for their enrollees. However, fee-for-service plans that pay providers on an indemnity basis and do not contract with providers to limit balance billing leave their enrollees vulnerable to potentially significant out-of-pocket costs.

For example, assume that a carrier pays heart surgeons \$20,000 for a triple by-pass operation, while a physician charges \$35,000 for that procedure. If balance billing were not limited, enrollees receiving surgery from that physician would be liable for \$15,000 in out-of-pocket costs.

### **Conclusion**

In conclusion, the Blue Cross and Blue Shield Association believes that in designing basic benefit packages, consideration should be given to the following important issues:



- Assuring flexibility in benefit design, by permitting carriers to offer multiple standard benefit packages or actuarially equivalent coverage;
- Assuring affordability of coverage, by balancing the desire for comprehensive coverage against the ability of employers and individuals to pay for such coverage;
- Assuring coverage of appropriate preventive services, to help move our health care system away from a focus on treating illness and toward a focus on maintaining good health; and
- Assuring flexibility in cost-sharing arrangements, to facilitate the development of innovative, cost-effective delivery systems while protecting consumers against significant out-of-pocket costs.

Thank you for the opportunity to present our views.

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Chairman STARK. Thank you.  
Mr. Doherty.

**STATEMENT OF JAMES F. DOHERTY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.**

Mr DOHERTY. Thank you, Mr. Chairman.

My name is Jim Doherty. I am the president of Group Health Association of America, which represents about three-quarters of the national HMO enrollment.

Our position on benefit packages has been fairly consistent over the years since the enactment of the Federal HMO Act in 1973 and some amendments to that law when we found that the benefit package had to have some adjustments in connection with the private market.

Basically, it is inherent in the philosophy of HMOs and their antecedent prepaid group practice plans that the benefit packages must be comprehensive in nature, and that while some minimal cost sharing is desirable, it should in no way be so high as to act as a barrier to receiving the necessary care.

We also believe that if you are going to discuss benefits, that you have to do some things that my colleague here is talking about in terms of refining outcomes research and adopting the standards that have been developed in terms of making sure that the care is accessible, available and affordable.

The final point that we would make would be the business of new technologies. We would hope that whatever this committee does in terms of national health care reform, that you put some sense and some kind of rules in the technology assessment game, so that the health plans themselves can make appropriate coverage decisions in the confidence that those coverages will have the necessary results and will have the beneficial results. As it stands now, we have problems with knowing when technology is experimental, when it is acceptable, and sometimes these decisions are made by juries, rather than people who are experts in the field.

So, in sum, we would stick to our proposition that the benefits offered under any program should be at least equal to those basic benefits which were set forth in the HMO Act in 1973 and as amended two times after that.

We would also point out that there are many occasions when additional benefits are inculcated as a result of demands from consumers, employers and others. A good example would be that prescription drug programs are not provided or required by the Federal HMO Act as a basic benefit, but yet 97 percent of the HMOs, according to our surveys, offer such a program, and some 80 percent of the members of HMOs are covered under those programs, so that we do have some kind of flexibility to add to the benefit package required by the act.

We hope you would keep those concepts as you go toward national health care reform.

Thank you.

[The prepared statement follows:]

**STATEMENT JAMES F. DOHERTY, PRESIDENT,  
GROUP HEALTH ASSOCIATION OF AMERICA, INC.**

Good morning. My name is Jim Doherty and I am the President and CEO of the Group Health Association of America, Inc. (GHAA). GHAA is the nation's oldest and largest trade association for health maintenance organizations (HMOs). Our member plans enroll approximately 75% of the nearly 40 million people enrolled nationwide in 550 HMOs.

We are here this morning to talk about a standardized benefit package. We support the concept of a uniform benefit package. We believe that this, coupled with other health care reform changes, will make it easier for consumers to make direct comparisons between health plans.

However, based on our decades of experience in financing and delivery of care, we do have a couple of concerns or caveats.

We believe the standardized benefit package should be a comprehensive benefit package with first dollar coverage and reasonable cost sharing, based on the "basic health services" requirements of the federal HMO Act. If it is instead a bare bones package, one which does not include preventive benefits for example, it will impede the ability to truly manage care. Ultimately this is not cost effective, and it also impacts on the quality of care received by patients.

Further, it is important not to create financial barriers to care. The Commerce Department estimates that the average family spent \$4,296 on health care in 1990; 32% of this was spent on out-of-pocket costs.

If the standardized benefit package is less than comprehensive, HMOs and others are forced to offer basic services as supplemental services. "Unbundling" and then rating these benefits separately makes them more much expensive and invites adverse selection. For example, if a prescription drug benefit were only available as a supplemental benefit, only those individuals truly needing the coverage would purchase this benefit. This would result in higher than average drug utilization and likely in higher premiums and cost sharing for this benefit.

We are also concerned about standardized copayments and deductibles. HMOs generally use copayments, a fixed dollar payment, for cost sharing. Currently, most HMOs do not use coinsurance or deductibles. Reasonable cost sharing can play an important role in influencing appropriate utilization, but it should not create a barrier to care. HMOs charge reasonable or nominal copayments to encourage access to preventive and primary care.

For example, the GHAA 1992 Industry Profile shows that all HMOs covered primary care visits with no limit on the number of appointments; while 76% required a copayment for primary care, it was usually \$5 or \$10. All HMOs also provided unlimited hospital services, 79% without patient cost sharing. HMOs also provide extensive preventive services including prenatal care, well-child care, child and adult immunizations; also home health care, physical therapy, mental health and substance abuse services, and, of course, emergency services. Prescription drugs were covered by 97% of the HMOs surveyed and typically required a \$5 copayment.

We believe that the standardized benefit package should be equal to that required under the federal HMO Act. This is important if tax deductibility is based on a standardized benefit package. However, if the federal standardized benefit package is less comprehensive than current HMO Act requirements, the offering of "supplemental" benefits up to the level required by the HMO Act should not be penalized.

We are pleased that many members of Congress and this Administration now recognize the value of preventive services. HMOs have pioneered in this area and we have substantial data that shows the cost effectiveness and quality difference in providing access to these services.



Let me offer just one example. Group Health Inc. in Minneapolis, now known as HealthPartners, began a special preventive pre-term birth program. After 3 years, they found they had reduced the pre-term birth rate by 36%. Besides improving the quality of life, there were enormous cost savings. The costs for the thirty patients at high risk for pre-term delivery enrolled in the prevention program were compared to the costs for those high risk patients not enrolled in the program. The total costs of the mothers' and babies' care averaged \$10,662 for the cases in the prevention program. The total cost per pre-term delivery of those not in the prevention program averaged \$28,903, for an average savings of \$18,241 per high risk pregnancy.

To the extent possible, we believe a comprehensive benefit package should be specified in legislation. Or, if left to an independent board to determine benefits, there should be strong congressional intent and an explicit statement that state the standard benefit be comprehensive in scope.

An area where we believe a national board can play a valuable role relates to new technology. By establishing an independent, apolitical board to make decisions on coverage for new procedures, you remove these decisions from the courts and the realm of uninformed public opinion which often makes for coverage decisions which are not based on medical efficacy and appropriateness.

Finally, while there are many other components of a reform approach which go along with a standardized benefit package, we would like to highlight one area - insurance market reform. Changes in pre-existing condition and medical underwriting practices must be made - everyone should be required to follow the same rules. Along these lines, adjustments in contributions to health plans must be made so that health plans are appropriately paid not just for who they enroll but how well they manage the care.

Thank you for the opportunity to testify on this issue. We look forward to working with this Subcommittee as work on health care reform proceeds. I'd be happy to answer any questions.

Chairman STARK. Thank you.  
Ms. Deckert.

**STATEMENT OF MARY DECKERT, ASSISTANT VICE PRESIDENT  
FOR GOVERNMENT RELATIONS, EMPLOYERS HEALTH IN-  
SURANCE CO., GREEN BAY, WIS., ON BEHALF OF THE  
HEALTH INSURANCE ASSOCIATION OF AMERICA**

Ms. DECKERT. Thank you, Mr. Chairman and members of the committee.

I am from Employers Health Insurance. We are the Nation's ninth largest health insurer in the country and insure over a million people who work for small business. We also were recently hired by the State of California to administer and market its newly created HIPC, the first such purchasing pool enacted posthealth care reform.

I do appreciate the opportunity to testify on behalf of the Health Insurance Association of America and its member companies. Like you, HIAA member companies are deeply concerned about our Nation's health care system and we are committed to radical change of that system.

I believe we share the same goals, to achieve universal coverage and control costs, and we believe a defined benefit package is part of that goal.

As with so many other witnesses this morning, I am not here today to tell you which specific services or procedures should be included in the essential benefit package. Rather, I am here to offer our expertise in helping you understand the costs and benefits of the various options you may be considering.

Having said that, however, the HIAA has identified a number of issues and tradeoffs that we believe should be taken into account. We do not believe in a bare-bones or stripped-down benefits package. Rather, we support an essential package of services that includes preventive services and primary care, as well as covering catastrophic medical expenses. Coverage should be adequate and equitable for all Americans, with people receiving comparable care, regardless of income.

HIAA believes the benefit package should emphasize personal responsibility in preventive care. From our experiences in paying claims and managing both large and small cases, we have come to understand the benefits of what are known as "wellness" activities, benefits that don't just save health care costs, but lead to higher quality, more productive lives.

For example, a 2-year study of our own employees at Employers Health showed a 25-percent drop in the amount of sick time away from work among those who entered our in-house wellness program. Other examples are provided in my written testimony.

As worthy as every benefit is, however, it is also important to understand that tradeoffs may be necessary. Each additional benefit will make the package more expensive and more difficult to achieve affordable universal coverage. Perhaps most important, the richer the benefit package, the more subsidy small employers and the poor will require.

When deciding which benefits to include in the standard package, the designers must walk a fine line. Coverage for effective

treatments in the global sense is our ultimate goal, but our experience in the State is telling. Once a benefit has been mandated, it becomes politically impossible to remove, no matter how ineffective it has ultimately proven to be.

The task before you is indeed daunting. The HIAA calls for the Federal Government, through a self-regulatory entity comprised of all segments of the health care system, to define the essential benefit plan, as well as conduct technology assessment and outcomes research. This body would prioritize technologies based on the medical efficacy and costs. These evaluations would provide information about which technologies should be provided, under what conditions, and whether they should be included in the essential package of coverage. As a result, medical technologies, especially new and expensive ones, will be more equitably available and appropriately controlled.

The HIAA is pleased health care reform has reached the top of the public agenda. We believe that a reform package should move us from the present risk selection system to one focused on risk management. Toward that end, the HIAA supports insurance reform such as guaranteed issue and renewability, rating and underwriting restrictions and preexisting condition limitations, to eliminate risk-based marketing by insurance carriers.

That concludes my testimony. The HIAA stands ready to help the committee in any way it can, and I would be happy to answer any questions.

[The prepared statement and attachment follow:]



**STATEMENT OF HEALTH INSURANCE ASSOCIATION OF AMERICA,  
PRESENTED BY MARY DECKERT, EMPLOYERS HEALTH INSURANCE CO.,**

Good morning Mr. Chairman, I am Mary Deckert, Assistant Vice President of Employers Health Insurance, headquartered in Green Bay, Wisconsin. Employers Health is the ninth largest group health insurer in the country, and insures over a million people who work for small business. Our market focus is on employers with 2-50 employees. I appreciate the opportunity to testify on behalf of the Health Insurance Association of America and its member companies on some of the considerations you will have to address if Congress chooses to design a standard benefit package.

During the past year, HIAA has developed a Vision to reform America's health care system. A copy is attached to my written testimony. In our Vision, we call for the federal government, through a self-regulatory entity comprised of all segments of the health care system, to define an essential package of coverage that all Americans should receive. While we have identified some broad parameters for the essential package, we have not defined the specific items to be included in it. We have, however, identified a number of issues and tradeoffs that we believe should be taken into account when making these decisions.

I am not here today to provide you with our version of the essential package of benefits, that is, to tell you the specific services or procedures to include. Rather, I am here to express our willingness to lend our expertise in helping you understand the costs and benefits of the options you may be considering.

HIAA believes that the essential benefit package should not be a "bare bones" or stripped-down insurance package. Coverage should be adequate and equitable for all Americans, with people receiving comparable care regardless of income. We also believe the essential benefits should include primary care and preventive services, as well as covering catastrophic medical expenses.

The design of the essential benefit package should do four things:

1. Promote a healthy and productive life for all Americans;
2. Provide compassionate care to those who are chronically or terminally ill;
3. Encourage all Americans to take personal responsibility for their own health; and
4. Recognize that heroic efforts to extend life are not always appropriate or desired by individuals and their families.

As I mentioned, the benefit package should emphasize personal responsibility and preventive care. Many organizations, including the U.S. Preventive Services Task Force, have recommended a series of tests and interventions appropriate for various life circumstances which could, if followed, greatly reduce the need for more costly care later.

For example, AT&T Communications estimates that it will save \$72 million from reduced heart attacks and an additional \$15 million from reduced cancers if present trends in their wellness program continue. General Electric Aircraft in Cincinnati found that those who participated in their on-site exercise program were absent from work 45 percent fewer days than those who did not. And a two year study of our own employees at Employers Health showed a 25 percent drop in the amount of sick time away from work among those who entered our in-house wellness program.

It is critical the package balance the breadth of coverage with its costs. Every additional benefit will make the package more expensive, and more difficult to achieve affordable universal coverage. Given the federal government's budgetary constraints, perhaps more importantly, the richer the benefit package, the more subsidies small employers and the poor will require.

But the costs associated with additional services are just one consideration. Our experience with more than 800 state

mandated benefits is that utilization increases exponentially after new benefits are mandated, and not always in the best interest of the consuming public.

For example, in my home state of Wisconsin, the Insurance Commissioner determined that a mental health mandate increased the cost of insurance there by 25 percent. Shortly after the mandate was enacted, several dozen for-profit mental health hospitals popped up all over the state and our care management area reported that the vast majority of precertifications for mental health services were for the exact length of the state mandate, 30 days inpatient and \$7,000.

In 1988, the House Committee on Small Business held a series of hearings about fertilization clinics. Horror stories abounded from clinics in Virginia created shortly after the state enacted an in vitro fertilization mandate. They which took tens of thousand of dollars from health care consumers, did not produce one baby, and performed several unnecessary and perhaps harmful procedures in the process.

The difficult task before your committee will be to balance the need for coverage with the effectiveness of certain procedures, combined with costs. And, as I know you are aware, consumer protection issues abound.

When deciding what specific benefits to include in a standard package, the designers must walk a fine line. Coverage for effective treatments in the global sense is our ultimate goal. But our experience in the states is telling. Once a benefit has been mandated, it becomes politically impossible to remove no matter how ineffective it has ultimately proven to be. The task before you is daunting.

There are several ways to define an essential benefit package:

- The traditional way would be to specify providers and services covered, perhaps adopting the benefits offered by federally qualified HMOs.
- Or, the package could be defined in terms of a dollar amount of the annual cost of benefits. The annual cost could be a specified percentage of average income. Any combination of primary and preventive benefits with catastrophic protection could be included within the dollar amount.
- Another approach would be to specify conditions and treatments prioritized by their cost-effectiveness.
- A fourth way would be to define the package in terms of the structure of the financing and delivery system offering the coverage.
- Finally, the package could be defined in general terms such as "medically effective services appropriate to a particular patient," while giving providers the right incentives to decide what is best for the patient in each case.

One of the other duties that HIAA envisions for government is to oversee a the self-regulatory body that conducts technology assessment and outcomes research. This body would prioritize technologies (i.e. drugs, procedures, and equipment) based on their medical efficacy and their cost. These evaluations would provide information on which technologies should be provided, under what conditions, and whether they should be included in the essential package of coverage. As a result, medical technologies, especially new and expensive ones, will be more equitably available and appropriately controlled.

Information on the cost-effectiveness of a technology is very important -- it's the missing link we don't have access to today. The technology assessment function conducted by this quasi-governmental entity will play a critical role in helping to determine and evaluate the essential package of coverage. While

some technologies should receive favorable tax treatment, other new and emerging technologies which are not cost-effective should not be subsidized by the government.

In addition to determining which benefits to include, the designers will have to face other key questions. What, if any, variations in the essential benefit package will be acceptable? One single plan is unlikely to meet the needs or desires of every American. Allowing variations in the standard package has several advantages:

- It will satisfy more Americans;
- Encourage continued product innovation, which in turn will help control costs; and
- Allow employers to best meet the particular needs of their employees.

Some might argue that allowing variations will lead to risk selection by insurance companies. However, one main tenant of the health care reform package you are designing is to move from the present risk selection system to one focused on risk management. Insurance reforms such as guaranteed issue and renewability, rating and underwriting restrictions, and preexisting condition limitations will do far more to eliminate risk-based marketing by insurance carriers. Under the newly reformed system, carriers will compete on price, quality of care, and high service levels, winning the "satisfied customer game" only when excelling at these three items.

Mr. Chairman, that concludes my testimony. HIAA stands ready to help the Committee in any way it can. I'd be happy to answer any questions the Committee might have.





Health Insurance Association of America

#### VISION STATEMENT

*Our vision is a society of healthy individuals and communities. Our nation, through systemic change, will build upon our employer-based system to create a consumer-responsive, prevention-focused, affordable and cost-effective health system which fosters individual responsibility, human dignity, improved health status, and enhanced quality of life for all.*

#### VISION GOALS

- *Promote a healthy and productive existence for all Americans, maximizing the dignity and quality of life for each individual.*
- *Recognize, as a society, that heroic efforts to extend life are not always appropriate or desirable. Dignity, quality of life, and the potential of returning to a healthy existence must be considered in treatment decisions and in the allocation of resources.*
- *Provide compassionate care to all people, especially to those who are chronically or terminally ill and cannot recover from their illnesses.*
- *Encourage Americans to take personal responsibility for maintaining good health regarding lifestyle factors within their ability to control.*
- *Stabilize health care costs as a percentage of individual financial capacity--earned income and other sources.*
- *Harmonize health care spending with other essential national requirements--the environment, education, the economy and security.*

February 18, 1993

## GUIDING PRINCIPLES

Reform of our health care system requires comprehensive change. Change must include a shift in emphasis away from sickness and repair and toward health and wellness. The principles below comprise a unified whole, not a cafeteria menu. All elements integral to universal coverage and cost containment must be implemented together, not piece-meal nor staged over time one state at a time. HIAA believes that reform of our system must be guided by the following principles:

1. Reform must rely on competitive, pluralistic, and flexible delivery and financing systems in which all players--public and private alike--abide by the same rules. Government should not anoint winners; winners should be determined by the marketplace--a marketplace free to abandon failures and embrace promising new ideas.
2. Universal, "cradle to grave" coverage must be achieved by requiring all employers and individuals to pay for an essential package of benefits which should include primary, preventive and catastrophic coverage. Government cannot shirk its role; it must help subsidize those employers and individuals who cannot afford to purchase an essential package.
3. Insurers and other private payors must issue and renew coverage for all. To protect insurer solvency and maintain employer incentives to control costs and promote employee wellness, insurers can, within limits, establish premium rates which reflect risk. Coverage must be portable; there must be no pre-existing condition limits once in the system; and the problem of "job lock" must be eliminated.
4. Reform must build on our employment-based system. Employers' active participation in financing, selecting, and administering an essential package of coverage is critical to maintaining an open, flexible, and innovative health care system. Given their significant financial commitment, employers must retain control over their employees' health care coverage. Therefore, requiring employers to participate solely through group purchasing pools would invalidate the cornerstone of our employer-based system.
5. Changing the delivery system is fundamental. Managed care should be the primary vehicle for achieving sustained systemwide cost savings; we must allow it to evolve and develop into its next generation, including full participation of Medicare and Medicaid beneficiaries in managed care systems. A defining element of managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information. Employers and managed care systems will also provide incentives that promote healthy lifestyles and

personal responsibility. Managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

6. Government's role must be one of an enabler, not of a "doer". A primary and essential function must be to eliminate cost-shifting to private payors. Self-regulatory bodies will develop, implement and enforce rules of conduct for all players. These include rules of market behavior for all private and public payors, rules for providers to follow to ensure consistent payment levels which eliminate cost-shifting, and standards for electronic data interchange and for reporting outcome and cost information. Government-sanctioned self-regulatory bodies will also define essential package(s) of care, evaluate technologies for their cost-effectiveness, and establish a mechanism for pooling certain cost and utilization data. In addition, government must enact legislation reforming the malpractice adjudication system.
7. Tax preferences should be limited to the essential package of care, thereby motivating the public to seek the best value and providing additional revenue to finance expanded health care coverage.

#### *CREATING A WORKING HEALTH CARE SYSTEM*

We Americans have shorter life spans, higher infant mortality rates, and higher rates of violent death than do the citizens of other industrialized countries. Yet we pay more for health care per capita and more in total health costs--close to \$900 billion a year--than does any other country in the world. Furthermore, an estimated 37 million people in the United States do not have health care coverage; if we as a society continue "business as usual," that number is expected to reach 40 million by the year 2000.

To make matters worse, the private sector has had to shoulder more than its fair share of the costs. The Prospective Payment Assessment Commission estimates that, in 1990, private payors paid \$22.5 billion more than the costs incurred by their hospital patients to make up for losses hospitals experienced from the uninsured as well as Medicaid and Medicare patients. Put another way, private payors paid an average of 128 percent of actual provider costs; this amounts to almost a 30 percent "tax" on hospital costs paid by the nation's employers.

Clearly, these trends must be reversed. Over the last year, the Vision Committee of the Board of Directors of the Health Insurance Association of America (HIAA) met to discuss health care reform. The Committee members approached their task as



Americans who happen to know about health insurance rather than as health insurance executives who happen to be Americans.

HIAA's vision is a framework for comprehensive reform. Its underlying premise is that everyone with a stake in the success of American health care, including insurers, will have to do what it takes to create a working health care system. It reflects the conviction that the nation's health care needs can best be met by a competitive and pluralistic system, not a monolithic one, and that the private sector will continue to play a dominant role in financing health care. It calls for universal coverage for all and changes in the behavior of providers, payors, including insurers, and the public. It advocates that government be an "enabler," not a "doer," that it eliminate cost-shifting, and that it establish guidelines for everyone to follow. Our vision is premised on comprehensive reform; all initiatives central to its goal of universal coverage and cost containment must be implemented together, and in coordination with one another, to ensure maximum success.

Taken together, these reforms will lead to a sustainable reduction in the growth of health care costs and improve the health of the American people. We recognize, however, that these reforms will require significant new government spending. We have identified one possible revenue source--a limit to the tax preference employer-sponsored health insurance currently enjoys--but we recognize that other sources will be needed as well. It is critical that these newly generated tax dollars be applied only to building a health care system that will produce long-term sustainable savings; new revenues should not be wasted perpetuating the status quo.

The health insurance industry anticipates further discussion on many aspects of the system it proposes. Some areas need more thought, and some gaps need to be filled. As areas of uncertainty are clarified, this paper, which is not final, will be modified to reflect these changes. Some lack of specificity will have to be tolerated while we struggle to find solutions to difficult issues. (For purposes of this discussion, "health care" refers to services to prevent, diagnose or treat medical conditions. The reforms proposed here do not apply to coverage outside of the essential package, such as disability income, supplemental hospital indemnity, specified disease, Medicare supplement or long-term care insurance.)

#### COMPONENTS OF THE NEW SYSTEM

##### 1. *Based on Pluralistic Financing and Delivery Systems*

Reform must rely on market-based pluralistic and competitive financing and delivery systems. Pluralism and choice are what engender competition--competition among ideas, among companies, among plans, and among values such as cost, quality and convenience. Only true competition can assure that our health

care system remains flexible and open to innovation, so that it will continue to evolve to better meet consumers' needs in the future. A system with many buyers and sellers will assure breadth and depth of services and responsiveness to consumers. Market forces must be allowed to determine which systems shall succeed.

Comprehensive health care reform will require an expanded federal role to eliminate costly variations in state regulation and assure uniform standards--a level playing field--for all public and private payors. It will also require that government remove barriers to the growth of pluralistic, competitive systems.

## **2. Builds on an Employer-Based Foundation**

Employers have a unique interest in maintaining employee health--as it affects productivity. Therefore, employers must provide coverage for all their employees and dependents. Employers will pay for at least part of this coverage. Some employers will receive government assistance to help cover their employees.

All employers, regardless of their size, will select plans based on the performance of competing managed care systems. A system built on an employer base is categorically inconsistent with the concept of exclusive group purchasing that bypasses employers altogether, thus relieving them of their responsibilities. Purchasing pools, such as group association and multiple employer plans, are common methods of obtaining coverage. We have no objection to a variety of demonstrations and experimentation with other forms of purchasing pools provided employer participation is voluntary. In no case should employers be required to buy health insurance solely through group purchasing arrangements.

A competitive and pluralistic system should allow purchasing pools to exist side by side with other methods of arranging coverage. Insurance reform measures will prevent any one entity from bearing an inequitable share of risk because all payors will follow the same market rules to guarantee coverage.

In addition, employers should:

- be free to experiment with and invest in a variety of approaches in providing an essential package of coverage;
- provide incentives to promote healthy behavior; and
- have incentives to help restrain costs because some element of their experience is considered.

### 3. *Achieves Universal Coverage for an Essential Package*

All Americans will have continuous coverage for an essential package of primary, preventive, and catastrophic care. Achieving universal coverage will require a series of mandates--on government, employers, insurers and individuals. How to divide these responsibilities will probably be the most difficult and controversial aspect of health care reform. Ultimately, it will be a political decision, not a health care decision. Clearly governments--federal and possibly state--will bear the cost of covering low-income people. Employers, in our view, should at the very least be required to incur the costs of offering health insurance to their employees.

HIAA supports a requirement that employers help pay for coverage for their employees and dependents. Even a modest employer payment would heighten employer cost consciousness and help restrain health care inflation. So-called employer mandates, however, are in effect a mandate on employees as well as employers, since employee premium contributions are envisioned in virtually all employer mandate plans. We are reserving judgment on how the costs should be shared between employer and employee, recognizing that there are practical limits on the ability of both employers and employees to shoulder the financial costs of a health care mandate. It may be necessary--however the cost is divided--to phase in the mandates over a period of years, taking account of any other employer mandates--such as increases in the minimum wage--that may be imposed at the same time. If an employer mandate is phased in, it will be necessary to coordinate it with other aspects of health care reform. For example, certain aspects of insurance market reform are not feasible absent a mandate; the two reform measures must be synchronized.

To achieve universal coverage, the following steps must be taken:

- Government must require all employers to arrange and help pay for an essential package of coverage for their employees and dependents. All individuals--those employed and those not connected to the work force--are required to obtain such coverage.
- Government must help employers and individuals who cannot afford to purchase an essential package. (Certain employers receive financial help, but they cannot "opt out" by paying a tax instead.)
- All individuals--those employed and those not connected to the work force--must receive the same tax incentives to purchase an essential package.
- The essential package covers primary, preventive, and catastrophic care. Government will authorize an independent body of providers, payors, employers and consumers to define the essential package of coverage. The design of this package must be flexible to encourage cost-conscious



behavior; it must have inherent limits to prevent continuous expansion, recognizing that people's wants and desires may exceed society's resources; and it must not overlap or duplicate medical care coverage available elsewhere such as under workers' compensation and automobile insurance.

- There should be no difference in the essential package of coverage received by the poor and the non-poor. Government will finance coverage for low income individuals, but there will no longer be the need for a separate Medicaid program.

#### **4. Ensures Universal Coverage Through Market Reform**

Market reform must be premised on a government requirement that all individuals and employers purchase coverage. In this environment, all health plans will be subject to national rules of market behavior to guarantee universal and continuous coverage. The same rules will apply to all health plans, whether offered by commercial insurers, Blue Cross/Blue Shield plans, HMOs, self-insured employers, government, or any other entity. Problems such as "job lock" and lack of coverage for pre-existing conditions will be resolved. The rules of market behavior will:

- require that coverage be made available to every employee in an employment-based group;
- assure that every individual will be able to purchase the essential package, regardless of their health, financial or employment status;
- guarantee that coverage will not be cancelled, terminated or not renewed based on the health status or claims experience of any individual or group;
- prohibit insurer rating practices that create large rate differentials for groups of similar age, sex and geographic composition;
- maintain, at the same time, insurers' ability to calibrate rates to risk--pure community rating results in market disruption and works against cost containment in a variety of ways; and
- establish a form of reinsurance or risk-sharing to compensate for inequitable distribution of risk.

#### **5. Creates Sustained Cost Containment By Systemic Change in Financing and Delivery Systems**

Changing the health care delivery system is fundamental. The actual delivery of care must be substantially better organized than it is today to meet the needs of patients, purchasers, and providers. Therefore, managed care should be the primary vehicle

for achieving sustained systemwide cost savings, and must be allowed to evolve and develop to its next generation. Managed care systems will serve the health care needs of communities by offering essential packages of care; they may also offer supplemental coverage.

Different forms of managed care coverage will compete on a level playing field. These competing forms of coverage include plans employing managed care techniques such as utilization review as well as managed care structures such as HMOs, PPOs, other network-based health plans, and evolving models. However, a defining element of all managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information across managed care systems.

Managed care systems will be permitted to pay providers in a variety of ways that encourage cost-effectiveness and quality care, including physician risk-sharing incentives, so that providers are rewarded for the cost-effective use of medical resources. New payment systems should encourage greater provider autonomy in decision-making and reduce the "hassle factor" that now results from micromanaging by payors.

Managed care systems will be user-friendly, efficient, and paperless. Administrative costs, and waste and fraud, will be significantly reduced. Improved alliances between providers and insurers will promote enhanced financial and managerial control of managed care systems, timely and responsive customer service, quality assurance programs, and fraud prevention.

Both managed care systems and employers will provide incentives that promote healthy behavior including discounts, promotions, and education. These incentives will reduce health care costs related to unhealthy lifestyle choices and will promote personal responsibility for one's health.

Given government's enormous buying power and its ability to influence provider costs, there should be strong incentives, perhaps requirements phased in over time, that Medicaid and Medicare beneficiaries fully participate in managed care systems to eliminate cost-shifting and control costs and utilization.

As managed care continues to develop, it will result in significant cost containment. However, managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

## 6. Controls Systemwide Costs Via New Government Role

Government will establish an entity that oversees and relies on one or more self-regulatory bodies to develop, implement and enforce rules of conduct for all players in the health care system. The regulatory framework will include all interested parties in the health care system--providers, insurers, employers, government, and the public. One, or possibly several, self-regulatory bodies will perform the following functions:

- establish consistent rules of market behavior for all health plans--those provided by insurers, self-insured employers, HMOs, government, or any other entity (see point 4);
- define essential package(s) of coverage that is made available to all, regardless of their income, age or employment status (see point 3);
- establish rules for providers to follow which ensure that they set consistent payment levels for all public and private payors for the same service. These rules should:
  - recognize that different payors may use different payment methods; and
  - assure that payments reflect real economic costs and value to providers and payors (such as convenience, service, adherence to quality standards, cost-effective practice patterns, or meeting additional contractual obligations).

(In no case, however, should the rules allow providers to grant discounts to one payor simply by increasing the cost to another payor. The most important outcome of these new rules is to eliminate government's chronic failure to pay the true costs of care for poor and elderly Americans. In other words, Medicaid and Medicare should no longer receive special deals with providers at the expense of the rest of the population.)

- develop standardized guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system;
- evaluate technologies (i.e., drugs, procedures, and equipment) for their cost-effectiveness; sanction clinical guidelines (developed by appropriate professions) that can be used as legal defense against malpractice claims; determine valid experimental treatments eligible for reimbursement through participation in clinical trials;
- establish standards for the reporting of outcome and cost information published by managed care systems;



- establish a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis to assist all payors in controlling costs and utilization, to help managed care systems produce outcome and cost data, and to help the government-authorized entity to develop guidelines that ensure that providers set consistent payment levels;
- enact legislative reforms of the malpractice adjudication system;
- enact legislation that allows insurers to exchange information for the purpose of identifying fraudulent providers; and
- consider actions needed to change the mix and supply of physicians and to increase the supply of physicians in inner cities and rural areas.

#### 7. *Establishes Equitable Rules for All*

Government will require all public and private payors to play by the same rules. To achieve this level playing field, the regulatory framework must:

- avoid duplicative or overlapping regulation among the states or between the state and federal levels;
- remove all state regulatory control over anti-managed care laws, mandated benefits laws, and provider contracting laws;
- prohibit states from mandating additions to the essential benefit package; and
- amend ERISA to allow this regulatory structure to successfully implement the above responsibilities.

#### 8. *Promotes Equitable Tax Policy*

Government must implement tax policies that eliminate perverse incentives for health care spending.<sup>1</sup> An unlimited tax preference for employer-sponsored health benefits does not promote cost-consciousness among employees. Instead, tax preferences for the essential package of coverage should be:

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<sup>1</sup>As noted earlier, this vision addresses reform of the acute care medical system; it does not address long-term care financing reform. HIAA continues to support several recommendations in the latter area, including favorable tax treatment of long-term care insurance, on the grounds that the increased availability of affordable private insurance will have a significant impact on reducing future public (Medicaid) spending on long-term care.

- capped at a level equal to the essential benefit package;
- extended to the self-employed and to those who purchase the coverage outside of an employment setting;
- inapplicable to any premiums for health benefits in excess of the essential package; and
- inapplicable to cost-sharing requirements, such as deductibles and copayments, for the essential package.

Employers would continue to be allowed to deduct 100 percent of their contributions to employees' health coverage, even if their contributions are for coverage in excess of the essential package. (But employees are taxed on the excess.) In addition, the inequitable taxation of various payors must also be addressed to help level the playing field in the new system.

The revenues from these tax changes should be used only to help pay for health care reform. HIAA could not support these tax changes if cost-shifting is not adequately addressed or if the revenues generated from these changes are not specifically applied to health care reform.

#### *SYSTEMIC FACTORS DRIVING COSTS ARE SLOWED*

We have proposed many ways to create a sustained reduction in the growth of health care spending. Everyone will have continuous coverage so people will not wait until they are ill before seeking care. Managed care systems will discourage excess doctor visits, unnecessary hospital and specialist care, and technology use that is not cost-effective. Physicians will be empowered to practice effective, not defensive, medicine. Managed care systems will offer essential packages of care that will compete on price and value.

Providers will not be able to shift costs among payors, so true market competition will compel providers to become more efficient. A government-authorized entity will evaluate, and slow the use of, expensive technologies that are not cost-effective. Administrative simplicity, a paperless system, and standardized claim forms will save money and help control fraud and waste. Coverage of preventive care and incentives for healthy lifestyles will pay off over the long-run. Tax advantages will be limited to the value of the essential package of care, thereby motivating everyone to seek the best value.

Successful reform will yield measurable results and trends that will compare favorably to those of other nations on costs and on a variety of quality measures (such as mortality, percent who smoke, and height/weight standards).

HIAA will continue to refine its vision of health care reform. However, we are committed to achieving the objectives outlined.

Fixing the health care system will lift a sizable burden from our collective shoulders, yielding resources and liberating energies for other critical issues on the nation's social agenda.

#### SEPARATE ISSUE PAPERS

Additional issue papers are being developed on selected subjects. In some instances, these are descriptive papers discussing the pros and cons of the issue. In other cases, these are supplemental papers providing more detail than what is proposed herein. Topic areas include:

1. Price controls
2. Global budgets or expenditure targets
3. Extent of tax-favored treatment for health insurance
4. Precise nature of federal and state responsibilities
5. Cost estimates and revenue sources for reform
6. Implementation and enforcement of employer and individual mandates (including how much an employer contributes, which employees qualify under the employer mandate, and how a subsidy program could be structured)
7. Centrality of employers in providing coverage (including a discussion of the concept of group purchasing arrangements)
8. Insurance in the new market
9. Determining the essential package of coverage (including a discussion of supplemental coverages)
10. Medicare and Medicaid
11. Technology assessment
12. Tort reform
13. Individual responsibility, wellness and prevention
14. Measuring and assessing results with other nations
15. Medical care coverage under Workers' compensation and auto insurance



Mr. LEVIN [presiding]. Thank you.  
Mr. Snyder.

**STATEMENT OF MICHAEL B. SNYDER, MEMBER, BOARD OF DIRECTORS, ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, AND DIRECTOR, BENEFITS STRATEGY, EASTMAN KODAK CO., ROCHESTER, N.Y.**

Mr. SNYDER. Thank you.

The Association of Private Pension and Welfare Plans is pleased to be part of today's hearing.

Over 18 months ago, a special task force of APPWP members, representing its broad range of the private sector benefits community, was convened at the request of our board to determine an appropriate and comprehensive policy on health care reform. The task group worked for 15 months and produced a bold and detailed plan for health care reform. The plan provides for universal coverage and includes a basic benefits package guaranteed to all Americans. Our board approved the plan last December.

The APPWP already knows business is doing more than its fair share in providing coverage to over 90 percent of their workers. Employers also pick up the tab for uncompensated and undercompensated care, that is the Federal Government's underpayments on Medicaid and Medicare. But because we believe that the virtues of the employer-based system should be a model for the system as a whole, we have asked employers to do more. The APPWP proposal makes us the first major business organization to include an employer mandate to provide coverage to workers, a basic benefits package based upon the HMO Act, aggressive managed care for all Americans, including Medicare beneficiaries, a cap on the employee tax exclusion, spending targets with a possible last resort of rate regulation should targets not be met, and a Federal health board.

Let me stress that our concern for the package, as it was for the coverage issue itself, was that it be in the best interest of our employees and all workers. Employers are concerned in a very parochial way about the health and productivity of their current and future work force. It is a key element in any company's success.

One test for the adequacy of the package was, would we feel comfortable having our families covered by such a plan. We, therefore, rejected out of hand so-called bare-bones benefit packages as inadequate. We opted for the HMO Act package of services and treatments or its actuarial equivalence as the best model for a basic plan.

This package of benefits could be delivered through various plan designs. The HMO Act package is an extant concept, a package of benefits being successfully delivered to millions of Americans for decades.

We included the concept of actuarial equivalence, because employers need and demand flexibility in the operation of benefit plans. We are not suggesting the elimination from the package of any vital service or treatment, but, rather, some limited design flexibility to enable employers to provide appropriate plans to an increasingly diverse work force.

The plurality and flexibility of an employer-based system are highly valued by the American public; employees can best tailor benefit programs to fit individual needs. This flexibility permits technological and service-oriented developments to provide the best medical care in the world. As the needs of our employees change, so do the design of our employee benefit programs. Employers want and will demand a rational health care system that is driven by quality and cost effectiveness.

The APPWP does not believe that one-size-fits-all, flat-rate, globally budgeted systems and cookie-cutter benefit packages are the best ways to achieve these ends.

As you may recall, during the campaign, President Clinton repeatedly cited Rochester, N.Y., as an example of a successful health care model. Kodak, with its world headquarters in Rochester, has played a major role in the development and maintenance of that model. Our success in containing health care costs in the Rochester area is based on a community rating and managing capacity. It was achieved through employer, insurer and provider negotiation and cooperation. The flexibility offered by APPWP's plan is a necessary component for our continued success.

Our detailed proposal, a copy of which I have submitted for the record, is highly integrated. Many elements would not be acceptable independent of other provisions. For example, our employer mandate provision is tied to the benefits package. APPWP did not easily become the first business organization to endorse an employer mandate.

However, our member companies' commitment to the private system and their determination that the current state of our health care system was increasingly intolerable and led us to accept employer responsibility and other important policy decisions. Our mandate is tied to the value of the basic plan. Our board of directors would agree to a mandate only if they felt there was some deterrence to expanding its scope on a regular basis.

Our proposal would require that the Secretary of HHS determine the value of the basic plan for purposes of an employee cap on the health benefit tax exclusion. Thus, if Congress were tempted to expand the mandate, it would be with the knowledge that a richer plan would lower Treasury revenues.

We must provide all Americans with a sound health care plan, but we must also recognize limits, which is perhaps easier for the business community than for the political community. Business is at the health reform table today because of the impact of high health care costs on our economy and on our ability to effectively compete in world markets.

Also, we have many examples in our public benefit programs where the Government has overpromised, but underfinanced and underdelivered. Our suggestion on determining the value of the benefits package would be to weigh the average of the three most cost-effective providers of the basic plan in initially the five highest cost cities. Moderate cost cities would be added to the calculation to bring down the value. Using the more expensive cities at the start, however, would put them on notice that they need to make efforts to bring down costs, while at the same time not penalize them in the beginning.

Also vital to an employer-based system is continued ERISA preemption protection. Under the APPWP plan, which would sweep almost all employers into the health care system, the role and expansion of ERISA's protection become even more important, especially as it affects the growing predominance of cost containment programs. But the single regulatory framework that is provided through ERISA preemption is threatened by provisions currently under consideration in this Congress and is part of the President's health reform effort.

We emphasize here today that ERISA preemption protection and, indeed, the development of a Federal reform framework be included in the comprehensive Federal health care reform package. The added complexity of State-by-State reforms would only increase costs and confusion for multistate employers.

Our association firmly believes that a strong role for an employer-based private system for health care benefits is good for America overall, its industries and for the health of American workers and their families. Building upon the private system and leveling the playing field for all participants in the health care system is, we believe, the wisest course and basis for reform.

In supporting mandates, spending targets and benefit tax caps, the APPWP has dramatically altered 25 years of association policy. We did so after careful deliberations which produced a rational and comprehensive reform proposal that meets the President's call for shared sacrifice in order to achieve meaningful reform. We believe our plan has the best chance of preserving the employer-based system and it merits your close study.

Thank you.

[The prepared statement follows:]



**STATEMENT OF THE ASSOCIATION OF PRIVATE PENSION & WELFARE PLANS  
MICHAEL B. SNYDER, MEMBER, APPWP BOARD OF DIRECTORS  
AND DIRECTOR, BENEFITS STRATEGY, EASTMAN KODAK**

Mr. Chairman and Members of the Committee:

The Association of Private Pension & Welfare Plans is pleased to be a part of today's hearing on a standard benefits package as an element of health care reform. We're glad you've asked the question; we have an answer.

Over eighteen months ago, a special task force of APPWP members -- representing its broad range of the private sector benefits community -- was convened at the request of our Board, on which I serve, to determine an appropriate and comprehensive policy on health care reform. The Task Group worked for fifteen months and produced a bold and detailed plan for health care reform, which provides for universal coverage and includes a basic benefit package guaranteed to all Americans. Our Board approved the plan last December.

The APPWP already knows business is doing more than its fair share, covering 77% of American workers and their dependents; large companies provide coverage to over 90% of their workers. Employers also pick up the tab for uncompensated care and undercompensated care -- i.e., the Federal government's underpayments on Medicaid and Medicare. But because we believe that the virtues of the employer-based system should be a model for the system as a whole, we have asked employers to do even more. The APPWP proposal makes us the **first major business organization** to include an **employer mandate** to provide coverage to workers, a **basic benefits package** based upon the HMO Act, aggressive managed care for all Americans -- even Medicare beneficiaries, a **cap on the employee tax exclusion**, **spending targets** with possible last resort rate regulation should targets not be met, and a **federal health board**.

We spent a great deal of time and energy debating the elements of the benefits package. Let me stress that our concern for the package, as it was for the coverage issue itself, was that it be in the best interests of our employees, and all workers. Employers are concerned, in a very parochial way, about the health and productivity of their current and future workforce. One test for the adequacy of the package was, would we feel comfortable having our own families covered by such a plan? We therefore rejected out of hand so-called "bare bones" benefit packages as inadequate. We then considered several options.

First we attempted to look at a cross-section of health plans offered by our plan sponsor members and from that review develop a model package profile. We soon learned, as the old maxim says, one man's ceiling is another man's floor. So we searched for another approach.

We then thought perhaps simplicity might serve us best and that therefore we delineate the basic benefit package as "all appropriate treatments and services" (??) and have plan sponsors fill in the blanks, perhaps by determining an appropriate dollar value for the plan.

We abandoned that idea as too ambiguous and open to wide interpretation. So then we looked at the backdoor approach which is to defer such decisions to a representative, public-private, politically insulated board and have them decide. We rejected that idea because we felt a duty to help the Congress and the Executive Branch decide upon an appropriate level.

Instead we opted for the HMO Act package of services and treatments -- or its actuarial equivalence -- as the best model for a basic plan. This package of benefits could be delivered through various plan designs. The HMO Act package is an extant concept, a package

of benefits being successfully delivered to millions of Americans for over decades. It has withstood the test of time. And, we'd feel comfortable having our families covered by such a package of benefits.

We included the provision of "actuarial equivalent" because employers need and demand flexibility in the operation of benefit plans. We are not suggesting the elimination from the package of any vital service or treatment, but rather some limited design to enable employers to provide appropriate plans to their workers.

The plurality and flexibility of an employer-based system are highly valued by the American public and can best tailor benefit programs to fit individual needs. This flexibility permits technological and service-oriented developments that provide the best medical care in the world. As the needs of our employees change, so too do the programs we design and offer our employees change. Employers want and will demand a rational health care system that is driven by quality and cost-effectiveness. The APPWP does not believe that one-size-fits-all, flat rate, globally-budgeted systems and cookie-cutter benefit packages are the best ways to achieve these ends.

As you may recall, during the campaign President Clinton repeatedly cited Rochester, NY as an example of a successful health care model. Kodak, with its world headquarters in Rochester, has played a major role. Our success in containing health care costs in the Rochester area is based on managing capacity, and was achieved through employer, insurer, and provider negotiation and cooperation. The flexibility offered by APPWP's plan is a necessary component for our continued success.

Our detailed proposal, a copy of which I am submitting for the record, is highly integrated and many elements would not be acceptable independent of other provisions. For example, our employer mandate provision is tied to the benefit package. As you know, the APPWP has long opposed mandates but as of last December, the APPWP became the first business organization to endorse an employer mandate. This did not come easily, as you might imagine. However, our commitment to the private system and our determination that the current state of our health care system was increasingly intolerable led us to accept mandated employer responsibility, and other important policy decisions.

Our mandate is tied to the value of the basic plan. Our Board of Directors would agree to a mandate only if they felt there were some deterrents to expanding its scope on a regular basis. Our proposal would require that the Secretary of HHS determine the value of the basic plan for purposes of an employee cap on the health benefit tax exclusion. Thus if Congress were tempted to expand the mandate, it would be with the knowledge that a richer plan would lower Treasury revenues.

We must provide all Americans with a sound health care plan. But we must also recognize limits -- which is perhaps easier for the business community than for the political community. In fact business is at the health reform table today because of the impact of high health care costs on our economy, and on our ability to compete in world markets. Also, we have many examples in our public benefit programs where the government has over-promised, but under-financed and under-delivered.

Our suggestion on determining the value would be to weigh the average of the three most cost-effective providers of the basic plan in, initially, the five highest cost cities. Moderate cost cities would be added to the calculation to bring down the value, but using the more expensive cities at the start would put them on notice that they need to make efforts to bring down costs, while at the same time would not penalize them in the beginning.

Also vital to an employer-based system is continued ERISA preemption protection. Under the APPWP plan, which would sweep almost all employers into the health care system, the role and expansion of ERISA's protection becomes even more important, especially as it affects the growing predominance of cost containment programs. But the single regulatory framework that is provided through ERISA preemption is threatened by provisions currently under consideration in this Congress and as part of the President's Health Reform effort. We wish to emphasize here today that ERISA preemption protection -- and indeed the development of a federal reform framework -- be included in the new world of health care reform. The added complexity of state-by-state reforms would only increase costs and confusion for multi-state employers.

Our association firmly believes that a strong role for an employer-based, private system for health care and retirement income benefits is good for America overall, and good for the health of American workers and their families. Building upon the private system -- and leveling the playing field for all participants in the health care system -- we believe to be the wisest course and basis for reform.

In supporting mandates, spending targets and benefits tax caps the APPWP has dramatically altered twenty-five years of Association policy. However we did so after careful deliberations which produced a rational and comprehensive reform proposal that meets the President's call for shared sacrifice in order to achieve meaningful reform. We believe our plan has the best chance of preserving the employer-based system and we think it merits your close study.



Mr. LEVIN. Thank you.

I will just ask a quick question, and then Mr. Kleczka will take over. Some of you are rather cautious in your response to the question of what should be in a standard health benefit package. Is there a reason for that?

Ms. DECKERT. I guess I would start by saying that it is the position of the HIAA that defining a standardized benefit plan for all Americans is basically an issue of public policy, that we believe all of the stakeholders within the health care system have unique perspectives to bring to the table on that issue and should be listened to and become a part of the system on an equal basis. But to sit here and say that we have the only thoughts about what specifically should make up an essential benefit package is beyond what we believe is true.

Ms. LEHNHARD. I would also say I think we are struggling with the same problems you are. There are a lot of good benefits that we know the public would like to have in a package, but they increase the cost. This is why we have come to the conclusion that it may be best, particularly in the beginning, if small employers are picking up this responsibility, to have several options, but not unlike the medigap approach.

The whole issue of how broad is mental health, prescription drugs, long-term care, home health benefits, there may need to be some options in those areas, because small employers just are not going to be able to afford what many large employers have been providing for a long time.

Mr. LEVIN. I guess I need to go and vote. If you want to respond—Mr. Kleczka or others, forgive me—I will read the transcript.

Thank you.

Mr. KLECZKA [presiding]. Do any other panel members care to respond to Mr. Levin's question?

Mr. DOHERTY. We are not reluctant to have a defined benefit package and, as a matter of fact, we feel that you do have to have one, if you are going to have sensible legislation. Now, there can be variations within that package, but as I indicated in my testimony, in 1973, the Federal HMO Act was passed and it mandated a full set of comprehensive benefits.

It did have some exclusions, but we found that we could not sustain ourselves in our markets with that package, so that it was pared down a bit to where it is today and has been for the last 10 or 12 years, and it simply requires all inpatient and outpatient physician services that are medically necessary, it requires preventive health services, well-baby care, adult immunizations and this sort of thing, it is comprehensive.

The only area, Congressman, where you get into some tricky area is in the additional benefits such as the mental health area, where we do not provide and we are not required to provide an extensive mental health package. Under the law, we are required only to provide something like 20 outpatient mental health visits. Very few HMOs do that. They have been required, either by statute or by employers, to provide additional inpatient benefits and so forth, so that over 90 percent of the HMOs in this country do offer inpatient and outpatient benefits.

But when you get down to the point of cost and the point of marketplace competitiveness, you have to have a broad package, otherwise, health care reform does not mean anything, unless you can offer a comprehensive set of services, but you do have to look at the cost item, particularly when you are trying to cover those who are now underinsured or uncovered.

Mr. KLECZKA. Well, you bring up two points. You indicate to us that it has to be a broad package which also looks at cost. I don't think you can have both of them. If we do the Cadillac package with every available option and no cost controls, we are going to see the continuing spiral in health care costs.

Mr. DOHERTY. But if you have full inpatient and outpatient medically necessary services, then it becomes part of the health care environment. It is important, for example, that you provide prescription drug services despite the high cost; 97 percent of the HMOs in this country and 87 percent of the HMO members have that available to them and they do use it. It is usually paid by employers, with small copayments out of the employees' pockets.

My point is that you are always going to have this problem of cost versus benefits, but unless you have a basic comprehensive set of health care benefits, then you are not going to have the kind of measures that Dr. Straub is talking about. If people cannot get these benefits, what good is the outcomes or the new paradigm or the new scheme?

Mr. KLECZKA. But I think we are talking about a new basic plan, one which is not as comprehensive as some would like, and then the option for a supplemental plan, where if the family unit wanted additional coverage, they would go to the market and then provide a supplemental package for the family.

Dr. Straub, do you want to respond?

Dr. STRAUB. I guess maybe I would like to go back just a little bit farther in the discussion. I think it is very difficult to impose a standard benefit plan on the existing delivery system and expect not to have the cost just go through the roof. So I think that to look at the benefit plan in the absence of the provider system is foolhardy.

If the country goes toward a managed competition system, then we are going to have in all likelihood migration toward more and more HMOs, which are presumably more efficient as providers. In that scenario, the broad kind of plan which has been addressed makes some sense.

We started out about 3 or 4 months ago with a belief that you could really only have one standard benefit plan and that remains sort of our ideal and our goal. I think, in reality, if you are trying to reconcile the cost-access situation, you really may have to consider a basic plan in addition to a standard plan, and then mandate that that be phased out over a period of 4 or 5 years, so that all Americans—

Mr. KLECZKA. Phase out the standard plan?

Dr. STRAUB. Pardon?

Mr. KLECZKA. Phase out the standard plan?

Dr. STRAUB. Phase out the basic plan, which would be less costly and would be more affordable for small employers, et cetera, but have as a goal that in 5 years it is mandated that that is phased



out and you do come in with one standard plan. Other people have suggested that 5 years may be the timeframe that it will require for our provider system to come up to speed and become more efficient.

Mr. KLECZKA. Don't you think the reverse will happen, that if, in fact, we develop a basic plan, most employers who have coverage in excess of that will bring the coverage down, viewing that as what their responsibility is? Don't you think that will be the effect?

Dr. STRAUB. I think many of the rich plans out there, the employers would have a very difficult time taking that away from them, especially at once. I think if over some time some experience could show that the value delivered, if you will, in the basic plan may approach that of the standard plan, you might find the two actually come together. And it would also give you some experience on which to base some judgment.

You can see the debate that is going on here and you can reach in a hat, I would guess, and pull out any kind of plan you want—

Mr. KLECZKA. No one has brought a plan forward.

Dr. STRAUB. Right.

Mr. KLECZKA. So I guess they will leave that to us.

Ms. LEHNHARD. I would say that I think we all three are making the same point, that you need very comprehensive coverage for hospital inpatient and physician outpatient and perhaps prescription drug coverage, and then the cost issue comes as you layer on some of the other services that maybe the small employer might not offer.

Mr. KLECZKA. But the core you just identified, especially prescription drugs, are the largest cost centers.

Ms. LEHNHARD. That is right.

Mr. KLECZKA. So you cannot say cost savings with that core package you have just identified.

Ms. LEHNHARD. That is right. The point I would make about supplementary coverage is that is the way medigap was set up, that anything not covered would be a rider or supplementary coverage. Those, by and large, are not being offered, because when you break those benefits out of the benefits package and offer them separately, you are making yourself very vulnerable to adverse selection. The people who need it buy it, because it is not built into the package that everybody buys.

So that is at least something to keep in consideration and why we are thinking maybe you need multiple packages that could indeed be phased out, if people were able to move up and offer the richer, more comprehensive package.

Mr. SNYDER. I think that the APPWP's membership, which represents large and small employers, struggled and discussed this issue for 15 months, for two of the reasons you are stating.

First of all, in order to compete in today's economy, we cannot afford, as employers, to all of a sudden drop down to any minimum package that is being offered. We are competing for the best employees and that does not create a desirable situation for any employer.

Secondly, when we looked at options, we knew that employers had to have some amount of flexibility in their plans. When we talk about using the HMO Act as a basis or using its actuarial equiva-



lent, I think employers have showed over time that they are responsible enough and have to treat their employees in such a way that that is a way to come up with a benefits package that is both flexible enough and yet meets the demands.

Mr. KLECZKA. Thank you.

Thank you, Mr. Chairman.

Chairman STARK [presiding]. I want to thank the panel. I find many of your concerns interesting. I am particularly attracted to healthy lifestyles. Dr. Sullivan tried to sell us that for 4 years.

People in my district like the exercise part OK, but celibacy was a little tough to sell. [Laughter.]

Arguably, costs would have gone down.

Dr. Straub, there is a guy named Warner Erhardt in San Francisco who has a program sort of like yours, that led to the national hunger thing, you know, if we just think hard enough about hunger, it will go away.

It seems to me that all the evidence that we have been able to determine is that we are not going to have reasonable practice guidelines in anything less than 5 years, even if we started tomorrow collecting the data. What do we do in the ensuing 5 years?

Dr. STRAUB. I would agree with you it may take 5 years, maybe 10, but I think if you don't start now, you will be dealing 5 years from now with the—

Chairman STARK. What do we do for 5 years? If we are going to start this program on January 1, 1994, how do we determine the benefits that we start with, while we wait the 5 years for these cost-effective things to come into—

Dr. STRAUB. I think for expediency purposes and for public acceptability, et cetera, you do have to start with something that is basically conventional. We would just plant the seed of this notion in the plan, like I indicated, introduce a couple of these guidelines and let it grow over time.

Mr. KLECZKA. Doctor, I have a list here of nondoctor health providers, four pages, put together by the Source Book on Health Occupations. I have got athletic trainers and contact lens technicians and dance therapists, and all of these folks want to be in the club.

Regardless of whether Congress does it or some board does it, we have got to start now and hit the ground running to get costs down and to get going on a plan. You know, I wish we could wait until everybody agrees on one, but we are going to have trouble getting half of the Members of Congress plus one to agree on any one plan.

With HMOs, it is a little easier. We have a Federal standard, and I think we are going to have to insist on staff models only, because those are the only ones that we will get scored any savings for, and that is OK with me.

But in this other plan where we have to define—you were patient enough to hear Members of Congress talk about what we have to do for teenagers and what we have got to do for mental health, and we are going to hear more today and on into the night, if I don't end my question very soon. [Laughter.]

Where do we start? Do we start with a basic plan—and I don't mean like Medicaid, paying better, Medicare—and then add building blocks to that? What does the Jackson Hole Group tell us to do to get going?

Dr. STRAUB. I think you were out of the room earlier, but I did address that issue in the sense that we started with the notion and still believe firmly in a single uniform plan for all Americans.

Chairman STARK. OK.

Dr. STRAUB. But in trying to reconcile cost and access, we backed off of those position for what we would call a 5-year transition phase and offer more of what we would call a basic and less costly plan, in addition to a more ideal and standard plan, perhaps mandating, if you really believe in the idealism of having a standard plan for all Americans, then mandating that the basic plan be phased out over that 5-year period.

Now, I tied this to the provider system. I do not think you can look at the benefit plan sort of in a vacuum, if they are very closely tied to the provider system. The reasons that HMOs can provide broad comprehensive plans is that they are just more efficient as providers.

Chairman STARK. Some are.

Dr. STRAUB. Some are.

Chairman STARK. Some are arguably good.

Dr. STRAUB. Recent studies by Greenfield et al. that show 41 percent reductions in hospitalizations by HMOs within the last year, that is—

Chairman STARK. IMC did it even better, they didn't send anybody to the hospital. You know, they didn't even pay the doctors before the guy left the country. But peristalsis is even better. They stole \$13 million. You know, I could run an HMO and show you how to save a lot of money, but let's assume they are going to be honest.

Dr. STRAUB. This is medical outcomes study data published in the New England Journal which, in fact, looks at the quality of care coming out the other side. It is all corrected for demographics, age, et cetera, so I think it is good quality material. And I think if you do accept that and extend the notion that HMOs will in the future be more effective in delivering care, then you can offer a broad comprehensive plan. But if you take that broad comprehensive plan and superimpose it on a relatively inefficient fee-for-service system, then you are going to have problems.

Ms. LEHNHARD. Mr. Chairman, I would like to respond to part of your question about which providers you cover. I would venture that if Congress starts down the path of specifying which providers accountable health plans have to use, there will be tremendous political pressure put on you until you have covered all four pages of those providers, and that might well be something—

Chairman STARK. Which is probably why we are not going to use the HIPCs anyway, but go ahead.

Ms. LEHNHARD. That might be an issue that is well left to the accountable health plans, particularly to give them some flexibility in rural versus urban areas, for example.

Chairman STARK. You make this wierd assumption that there will be this universal HIPC thing out there which people have to join, and I would submit to you that in our next lifetime we may see this country accepting everybody having to join some co-op. One of the problems in getting real, is that there is this assumption, which I question, that we will require all Americans to join one of



these clubs. We can't even get them all in the AARP or the AAA or Alcoholics Anonymous or anything else. Americans are not, by nature, joiners and——

Ms. LEHNHARD. My point was to leave it to the accountable health plan like Kaiser or the HMO, not the HIPC, but the insurance plan itself or the provider network. They have tremendous discretion.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Snyder, I understand your concern on the ERISA statute and the preemption of State law, but I am wondering whether the problems that you are concerned about apply to giving the States the ability to establish rates for their providers? In Maryland, of course, we have an all-payer rate system that sometimes needs some consideration under the ERISA statute. So if the States only acted in the area of rate-setting, so that basically paying bills would be the only difference that you would confront. Do you have the same problems in regards to the States being able to act independently of the ERISA statute?

Mr. SNYDER. In other words, that would be rate-setting across the board, not for just Medicare, but for——

Mr. CARDIN. Correct.

Mr. SNYDER. Assuming that we were faced with that, I guess the next question would be how would that be administered? Would we, as our member companies facing workers in 50 different States, then be required internally to keep track of reimbursement in 50 different levels, or how would we go about——

Mr. CARDIN. Isn't that easier than the current system, where you have so many different rate settings for payers, depending on who is paying the bills?

Mr. SNYDER. At this point, what our employers are able to do is simply to put a plan in place that will go across State lines, without having to be concerned with any differences across the State. Yes, the providers may charge differently in States, but we don't start to run into a scheme that tells us in one State you must treat your employee this way and in another State you must treat your employee this way.

If we have an employee in Rochester, N.Y., who is used to a certain level of benefit, because we have been able to have a cost containment system in Rochester, and if that employee then moves somewhere where it is much more expensive, where does that leave us room as an employer to be able to set our own levels?

Mr. CARDIN. How difficult is it for you to be able to track? Assuming you operate in all 50 States on a given plan, which I think is maybe not realistic, but assume you do that, how difficult will it be to track an approved rate in one particular State that wants to use an all-payer rate system, let us say, just a matter of the approved fees and paying the bill when the bill is presented? I guess I don't understand the difficulty that it presents for you.

Mr. SNYDER. The difficulty comes in any time we have to start to look at an individual State or any type of individual mandate by State, it adds cost to our health care plan. When we add cost to our health care plan, it takes away from the profits of our com-



panies, which means that we have to start to think how to cut those health care costs down.

If we are given, as a company, the ability to deal with providers, once we have a mandatory benefit level, to deal with how we deliver that, then we are able to better serve our employees.

Mr. CARDIN. I understand. I guess our system is not exactly free from complexity today, even for the self-insured plans, and I would expect that the complexities would not be changed radically at all by allowing the State, particularly when we are saying it is an all-payer system, which makes it a lot simpler to enforce, that your computer system could accommodate that type of an exemption from ERISA.

Mr. SNYDER. Again, I guess the step before that would be that our employer group members would certainly have a hard time dealing with an all-payer system.

Mr. CARDIN. Pardon?

Mr. SNYDER. I think we would have a difficult time accepting the all-payer system as a basic premise.

Mr. CARDIN. From a policy point of view, but not from a complexity point of view. An all-payer system is certainly a lot simpler to deal with. You do not have to worry about negotiating. You are going to pay a fixed rate for the services that are provided, the same as what Medicare pays or Medicaid pays and everyone else pays. That is certainly a lot simpler than the current system, where you have got to pay for all the cost shifting that goes on and all the different complexities and trying to deal with what realistic cost is.

Mr. SNYDER. That could be to a certain extent more simple. At the same time, the employers who have been providing for their employees for a number of years may view that as a penalty, as slapping the hands of the people who have been providing for 90 percent of its workers having to change that delivery system that has been more than adequate and more than successful.

Mr. CARDIN. I am not sure I follow that. Why would you be changing your system because you are paying the bills according to a State approved rate structure?

Mr. SNYDER. Responding to the all-payer question. If we are going away from an employer-based system——

Mr. CARDIN. No, this is employer-based. All-payer does not mean it is not employer-based.

Mr. SNYDER. Just so we are talking about the same——

Mr. CARDIN. No, we are talking about all-payer, not single-payer.

Mr. SNYDER. OK.

Mr. CARDIN. And if you do cover any employees in the State of Maryland, currently you are paying on an all-payer rate system, and I am not aware of your administrative costs being any higher in the State of Maryland than it is in other States, probably they are less costly.

Mr. SNYDER. The mere fact of having to go from State-to-State, rather than a centralized system is more expensive.

Mr. CARDIN. I understand that.

Thank you, Mr. Chairman.

Chairman STARK. Then I gather that what you are suggesting, Mr. Snyder, is that you would like to have a universal Federal plan

and not have it divvied it up State-by-State, is that your testimony?

[Laughter.]

Mr. SNYDER. No, that is not what I am suggesting.

[Laughter.]

Chairman STARK. You want States to do it, or do you want the Federal Government to do it? Or no one, I guess that is the third choice. Which?

Mr. SNYDER. I guess I didn't follow the question. I could not hear you, because of the laughter.

Chairman STARK. You are talking about having 50 different programs in 50 different States, right?

Mr. SNYDER. I am talking about avoiding that.

Chairman STARK. Pardon?

Mr. SNYDER. I am talking about avoiding that problem.

Chairman STARK. And one way to avoid that is have one Federal program, right?

Mr. SNYDER. To have a Federal mandate of benefit level, that is right.

Chairman STARK. The same program in every State.

Mr. SNYDER. To have a federally mandated level that would be allowed to be met, that is correct.

Chairman STARK. In each State, the same program in each State, Wisconsin, Hawaii, the District of Columbia, right?

Mr. SNYDER. Of a standard benefit level, yes.

Chairman STARK. And not let it be set differently in each State.

Mr. SNYDER. That is correct.

Chairman STARK. That is what I thought your testimony was. Thank you.

I want to thank the panel very much for their participation.

Our next panel consists of Eugene Lehrmann, president-elect of the American Association of Retired Persons; Martha McSteen, president of the National Committee to Preserve Social Security and Medicare; Ann Kolker, director of public policy/health and reproductive rights, National Women's Law Center; Joan A. Kuriansky, chair of the Campaign for Women's Health; and Robert Griss, who is cochair of the health task force of Consortium for Citizens With Disabilities.

I would like to welcome you ladies and gentlemen to the committee. If you would find your seats, your testimony will appear in the record in its entirety, and we would ask you to summarize your testimony, if you could, in approximately 5 minutes.

Mr. Lehrmann, would you lead off?

#### **STATEMENT OF EUGENE LEHRMANN, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS**

Mr. LEHRMANN. Good afternoon.

I am Gene Lehrmann, president-elect of AARP. Thank you for inviting us to testify. Rather than walk through my written testimony, I would like to make four major points.

First, health care reform must be bold and address all the major problems in the current health care system. With substantial input from our members and volunteers across the country and with



their overwhelming support, AARP has developed a comprehensive proposal for health care reform called "Health Care America."

Health Care America would provide for universal access to affordable high-quality health and long-term care, a standard comprehensive benefits package, health delivery system reforms, systemwide cost containment, and fair and affordable financing.

Health Care America offers hope and security to all individuals, young and old. AARP recognizes, however, that there are many paths to this goal. We will use Health Care America as a standard against which to measure the effectiveness of other health care reform proposals and as a compass to guide the association's participation in the health care reform debate. The discussion of a standard benefits package is an essential part of that debate.

Second, benefits must be standard across health care plans and populations. Consumers now have great difficulty in comparing the value of different benefit packages. A single standard comprehensive benefits package available to all Americans, along with quality and price information on health plans offered in this package, would greatly enhance consumers' ability to choose wisely.

The benefits package should be standard across populations, as well. Principles of fairness, as well as medical appropriateness, suggest that employees of small businesses should receive the same benefits as employees of large businesses. The unemployed should receive the same benefits as their employed counterparts, and Americans of all ages should have access to the same level of benefits.

Third, the benefits package must be comprehensive and include hospital and physician services, prescription drugs, preventive services, mental health services and long-term care. The individual share of premiums, as well as deductibles and copayments, should be moderate, to avoid barriers to needed care.

Limits on consumers' total out-of-pocket liability are essential. Long-term care coverage should include nursing home care, personal care, rehabilitative and restorative care, homemaker services, respite care, adult day-care, and other services as needed. These services should be available, regardless of where the individual resides, at home, in an assisted-living facility or in a nursing facility.

Truly, comprehensive health care reform must provide for a full continuum of health services over a person's lifespan. To a family, there is no difference between spending \$30,000 on hospital care and spending \$30,000 on nursing home care. A proposal that fails to integrate care needs in a seamless web will not work.

Some would describe this benefits package as generous, but it is not a question of generosity. It is a question of providing the appropriate service at the appropriate time when it is needed, to avoid higher costs and perhaps inappropriate care down the road.

Fourth, systemwide containment is impossible without a comprehensive benefits package. If a standard benefits package is less than comprehensive, then health care reform would perpetuate the many gaps in people's health coverage evident today and spawn a new market of supplemental insurance programs. Under this scenario, systemwide cost containment would be impossible. Trying to enforce national spending targets that do not cover prescription drugs or long-term care, for example, would be like the proverbial



squeezing one end of the balloon. The costs would always pop up somewhere else in the health care system.

AARP recognizes that while a guaranteed comprehensive benefits package will reduce many of the health care users' out-of-pocket costs and make health care more equitable, it will require additional Federal resources. Some of this funding could come from health care providers or insurers who will benefit from reduced cost shifting and universal coverage.

You have begun today to address one of the twin problems in our health care system, and that is health care coverage needs of Americans. We look forward to subsequent hearings and discussions on the problems of health care costs. We welcome any questions you might have.

Thank you.

[The prepared statement follows:]

Statement of the American Association of  
Retired Persons on A Standard Health Benefits  
Package and Health Care Reform

Good morning. My name is Gene Lehrmann and I am President-elect of the American Association of Retired Persons (AARP). As a membership organization of Americans 50 years of age and over, AARP thanks the committee for this opportunity to present our views on guaranteed health benefits for all Americans.

Health care reform has finally made it near the top of our nation's agenda. For several years AARP and many others have pushed hard for comprehensive reform of the health care system. We are heartened and, frankly, enthusiastic that the President and Congress are poised to address a problem that has festered far too long.

This testimony will discuss AARP's proposal for health care reform and identify the critical elements of a comprehensive benefits package. It will also explore why comprehensive benefits are necessary for system-wide cost containment.

**"Health Care America": AARP's Plan for Comprehensive Reform**

AARP's plan for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members and leaders across the country. Three years ago, AARP established a set of principles for reform based on a core belief among our members that all individuals have a right to receive acute and long-term care services when needed. In February 1992, a draft of the Health Care America plan, based on those principles, was approved by the AARP Board and offered in draft form to the membership for discussion, debate, suggestions and modifications. Over the next year, AARP sponsored over 5,000 community meetings involving more than 300,000 people. Through its publications, AARP also engaged in a dialogue with its 34 million members, who consistently gave extremely positive responses to the plan. The AARP Board approved Health Care America in February 1993.

Health Care America has as its major goals:

- o universal access to affordable, high-quality health and long-term care;
- o comprehensive benefits;
- o health delivery system reforms;
- o systemwide cost containment; and
- o fair and affordable financing.

Its centerpiece is a strengthened and expanded Medicare program through which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits (see Appendixes A and B for a full list). Medicaid would be eliminated.

In addition to ensuring access, the system would continue to foster choice, diversity, and innovation in the delivery of health services. The system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules. Structurally, Health Care America could be organized either as a "blended" program of public and private coverage, or as a "single payer" program of full, tax-based public coverage.

**Medical Benefits.** Medical benefits would include comprehensive coverage of hospital and physician services; prescription drugs; mental health services; and prevention and screening services,

including dental, vision, and hearing screening. Out-of-pocket costs would be kept modest to ensure that all individuals could get the health care they need:

- o \$200 deductible per person or \$400 per family;
- o No copayment for prevention, screening, or in-patient hospital care;
- o 10 percent copayment for all other medical care;
  - o Out-of-pocket caps of \$1,500 for individuals, \$3,000 for families.

People with incomes at or below 200% of poverty could receive partial to full assistance with cost-sharing.

Health Care America would require that hospitals, physicians, and other providers in a state or local area receive the same payment for a service regardless of whether Medicare or a private insurer pays the bill. Payments would be designed to assure that primary care services are available in all communities and to emphasize health promotion and disease prevention. Quality of care would be improved using clinical practice guidelines, data on quality, and establishment of public quality assurance organizations.

**Long-Term Care Benefits.** Health Care America would establish a national program of high-quality long-term care, based on principles of social insurance. Services would be available to all who need them, regardless of age or income. Eligibility would be based on a nationally-uniform assessment of physical and cognitive functioning and include:

- o people who require "human assistance" with two or more activities of daily living;
- o people who require constant supervision due to cognitive or mental impairment; and
- o children under age 18 who cannot perform an age-appropriate activity of daily living.

Services would be comprehensive and include in-home, community-based, institutional, and rehabilitative services, as well as services in supportive housing arrangements such as assisted living facilities and board and care homes. The program aims to enhance, not replace, existing efforts by unpaid caregivers, to the extent possible.

Cost-sharing for long-term care would be limited so that beneficiaries would not face impoverishment as they do under the current Medicaid program. Services received in the home and community would be subject to a 20 percent copayment, up to an annual cap of \$1,500 for individuals, \$3,000 for families. People with incomes below poverty would incur no out-of-pocket costs; those with incomes between 100 and 200 percent of poverty would meet lower annual caps. People who incur both medical and long-term care costs would meet a "blended" annual cap of \$1,800 for individuals, \$3,600 for families (with lower caps for people with low incomes). Nursing home residents would be allowed to protect up to \$1,769 a month for the support of a spouse in the community, more for additional dependents. Single residents would pay according to a sliding scale, based on income. No one would pay more than 40 percent of the average cost of nursing home care (currently \$1,100 a month), and most would pay much less.

**Cost Containment.** Health Care America's cost containment strategy would feature explicit, nationally established targets for overall health expenditures. A Federal Health Care Commission would be created to establish reimbursement and other administrative rules that would apply to both the new Medicare program and private insuring entities. The commission would set national spending targets for various components of the health care system -- provider reimbursement, capital, public health, and education and research -- and then allocate these national limits to states in the form of state-specific targets.



States would be responsible for administering these targets and would be at financial risk for any spending above the total or individual components of the targets. States would retain sufficient administrative flexibility to meet those targets while addressing local needs and preferences. Overall, states would contribute somewhat less under this plan than they would otherwise.

System-wide limits on payments to health care providers would control both the price and volume of services. Balance billing would be prohibited. Organized delivery systems, clinical practice guidelines, technology assessment, service coordination, standardized "smart" cards, electronic billing, and utilization review would also help contain costs.

In addition, the long-term care program would contain costs through a service coordination system. Service coordinators would work within fixed budgets and would be at financial risk for cost-overruns, with provisions for outliers. Cost targets would be established for individual clients, but there would be flexibility to arrange for all clients' services within the aggregate budget. Payment rates for providers of long-term care services would be set at the state level, under federal guidelines. Home care providers would be paid at rates no higher than 65 percent of nursing home rates, and all balance billing would be prohibited.

**Financing.** Funding for Health Care America would come from five sources:

- o existing federal revenues from Medicare, Medicaid, and other programs;
- o current state spending;
- o an 8 percent payroll tax on employers electing to enroll their workers in the new Medicare program -- employers choosing private coverage would pay at least 80% of the premium;
- o premiums paid by those enrolled in the new Medicare program -- \$50 per month per adult and \$25 per month additional for families; and
- o new taxes.

It is estimated that the proposed health care system, including both medical care (i.e., preventive/primary/acute/transitional care) and long-term coverage, would require approximately \$112 billion in new federal tax revenues in 1993.

Most of the new tax revenue would come from one (but not both) of two tax options. One option is a new 3 percent income tax on income above \$15,000 for singles and \$20,000 for joint filers (applied to adjusted gross income; gross Social Security benefits including all benefits not currently taxed; and tax-exempt interest.) The other option is a 5 percent value-added tax (VAT), with exemptions for food, housing, and medical care.

Additional tax revenue would include:

- o a 5 percent surtax on corporate income to recapture the substantial savings to corporations in lower retiree health liabilities;
- o a doubling of the tax rate on cigarettes and alcohol; and
- o an increase in estate tax rates to their pre-1981 levels.

Tax credits would be available for people with low incomes who file tax returns.

Health Care America is a proposal that offers hope and security to all individuals, young and old. AARP recognizes, however, that there are many paths to the this goal. We will use Health Care America as a standard against which to measure the

effectiveness of other health care reform proposals and as a "compass" to guide the Association's participation in the health care reform debate.

### The Standard Benefits Package: A First Step in Health Care Reform

#### The Price of Today's Gaps in Coverage

Before turning to the policy arguments for a comprehensive standard benefit package, I want to highlight the human dimensions of today's gaps in coverage. Below are four representative stories from AARP members and their families across the country:

Bromide, Oklahoma. In 1982 at the age of 52, Billie had a heart attack. Because of this pre-existing condition, she could only purchase a health insurance policy that does not provide her adequate coverage. Her policy does not pay for any outpatient services, and the allowable fee schedule is well below prevailing costs of services. In 1990, Billie had bypass surgery and was in the hospital for 14 days. A few hours after her surgery, she began to bleed internally, so she went in for a second surgery. Her insurance company refused to pay for the second surgery to stop her internal bleeding. The company also refused to pay for the perfusion machine which kept the heart and lungs operating during surgery. In the end, Billie was forced to pay out-of-pocket \$20,000 of a \$45,000 hospital bill. As a result of the surgeries, Billie's deductible was raised to \$5,000 and her premium to \$262/month. Not yet eligible for Medicare and discriminated against in the private insurance market because of her health status, Billie has no other choice of coverage. Billie's savings are running out, and she is truly afraid that she will need another expensive surgery.

Levelland, Texas. Guy and Diana thought they had adequate health insurance before their son Dylan was born. Despite a normal pregnancy, Dylan was born with a genetic disorder that meant he could not swallow, breathe, or eat normally. After several operations and four months in the hospital--- all of it spent in intensive care--- Guy and Diana brought Dylan home. At the same time, their insurance company notified them that Dylan's care was not going to be covered because they did not have a catastrophic illness rider on their policy. Guy and Diana were forced to care for Dylan themselves for nine months. Even during several hospitalizations, Guy and Diana continued to provide most of Dylan's respiratory therapy and physical therapy on their own to save money. Eventually, without insurance and with Dylan's medical bills mounting, Guy and Diana were forced to seek public assistance. Dylan died after 13 months of constant care.

Palmer, Michigan. In 1986, Grace's husband Dick, who was 68 at the time, had a cerebral hemorrhage and a stroke while he was on a hunting trip in Canada. When Dick was stable enough to be discharged from the hospital, Grace took all responsibilities for his care, even though she herself was 66 and had osteoporosis and heart problems. "I chose to keep him at home even though it was killing me physically," Grace says. Although she was a nurse by vocation before she retired, Grace says that "a nurse wouldn't be allowed to work the number of hours that I did." Grace looked into getting respite care for her husband, but she found nothing that would meet his care needs. And, while Dick's hospitalization was covered by Medicare, all the extra supplies that she had to purchase for home care -- a total of \$15,000 -- were not covered. Dick died in 1989, and Grace says that it has taken her three years to recover both physically and mentally. "You lose friends in situations like these. I didn't know anything or anybody but Dick. There was nothing to fall back on and no time to rest," she says.

Miami, Florida. Eating everyday is a luxury for 80-year-old Maxine who lives on a fixed income of \$582 a month from Social Security. Her check does not go very far after the necessary bills are paid for her trailer home lot and rent, utilities,

telephone, car, and car insurance. With the little money that she has leftover, Maxine tries to purchase her five heart medications that cost her more than \$200 every two months. According to Maxine, the cost would be significantly more if you count the free samples that her physician occasionally gives her. Maxine has approached a local Catholic charity to seek financial aid in purchasing her medication. The charity has foot the bill for one of her prescriptions, but she is only allowed to turn to them once every six months. In the meantime, Maxine has tried her best to earn the money for her medication. She says, "I've held yard sales, and I have sold just about everything I have to sell. I make baby quilts, and it takes me about three months to make one of 'em. Sell it for \$50, but the material costs me \$12." Maxine must choose between her medication and eating everyday. She says, "You can't buy something to eat when you got to take a pill. I went to the grocery store this week and bought a pint of vinegar and a dozen eggs to get by. Sometimes some of my neighbors ask me over for dinner. There's some real nice people in the trailer park."

#### Why Benefits Must Be Standard Across Health Plans and Populations

There may be as many different benefit packages sold today as there are insurance company representatives to sell them. Letting these thousands of benefit plan "flowers" bloom has indeed expanded choice for individuals and businesses looking to pick the best plan. But it has also smothered the individual consumer in a field of uncertainty and confusion. Consumers now have great difficulty comparing the value of plans with seemingly small differences in services covered and cost-sharing requirements. This subcommittee and the entire Congress recognized the importance of standard benefits in the "medigap" market in 1990 and took a first step to limit plan variation. These medigap reforms have already helped older Americans choose more wisely.

It is likely that health care reform will maintain private insurance coverage for most Americans. A single, standard comprehensive benefits package available to all Americans -- along with quality and price information on health plans offering this package -- would greatly enhance consumers' ability to choose between different health plans.

A standard benefits package would also help make insurance work as it should -- to spread the risks of high health care costs across large groups. Now we have too many private insurance markets that force sicker individuals to pay extraordinary prices for comprehensive coverage while others pay substantially less for "bare bones" plans. By not covering prescription drugs, for example, an insurer renders its plan inadequate for anyone with a chronic illness or likely to require high-cost medication.

Not only should the benefits package be standard across health plans, it should generally be standard across populations as well. Principles of fairness as well as medical appropriateness suggest that employees of small businesses should receive the same benefits as employees of large businesses; the unemployed should receive the same benefits as their employed counterparts; and Americans of all ages should have access to the same level of benefits.

#### Why Benefits Must Be Comprehensive

If a standard benefit package is less than comprehensive, then health care reform would perpetuate the many gaps in people's health coverage evident today and spawn a new and substantial supplemental insurance market. The dangers of such a large reliance on supplemental coverage are twofold. First, millions of Americans who cannot afford supplemental coverage would likely be relegated to a second-tier of care. Second, containing costs in the supplemental coverage market would be extremely difficult and could jeopardize cost containment efforts in the rest of the health care system.



### What Does A Comprehensive Package Include?

In order to ensure adequate access to needed services and protect against unaffordable health care costs, the Association strongly believes that the standard benefits package should:

- o include both medical and long-term care benefits;
- o limit total out-of-pocket individual and family liability; and
- o set cost-sharing requirements at reasonable levels.

Medical Benefits. Clearly, a comprehensive package of benefits should include the most fundamental services such as those provided in a physician's office, an ambulatory care facility, or a hospital. In addition, AARP strongly recommends that the standard benefits package ensure universal coverage in three essential areas: prescription drugs, preventive care, and mental health care.

Universal coverage of prescription drugs is important because they are an integral component of medical treatment provided by physicians. About 60 percent of office visits in 1989 resulted in a medication being prescribed or provided. Not only does the coverage of prescription drugs ensure that the investment in physician services is wisely made, it also promotes access to what is often the most cost-effective form of medical care for a particular condition. Furthermore, prescription drugs are commonly covered now under employer-sponsored insurance plans and Medicaid. Largely because Medicare does not cover prescription drugs for the population that relies on them most, 55 percent of prescription drug costs are paid out of pocket.

AARP also believes that coverage of preventive health care in the standard benefits package is essential to addressing one of the most serious health system deficiencies today: inadequate access to necessary prevention services. Preventive care is a wise investment because it can save the expense of costlier treatments that would be required if a serious illness goes undetected. It can also improve health status and the quality and length of life, through reduced disability and increased functioning. Unfortunately, only one in four full-time participants in health plans offered by medium and large businesses had coverage for routine physicals or immunizations in 1989. In part due to this lack of coverage, 40 to 60 percent of children under age 2 have not received the recommended immunizations.

The increasingly important role that preventive care is gaining in our health care system was illustrated by a recent health care reform survey conducted on behalf of AARP. In this survey Americans of all ages expressed a strong public preference for a health care system that includes preventive health care. In fact, respondents ranked preventive care second only to "cost/willingness to pay" concerns as key components of a health care program.

Finally, the Association is concerned that mental health services may receive inadequate attention within a standard benefits package. We are aware of the possibility that the standard benefits package recommended by the President's task force may be based on those required of federally qualified HMOs. Although these customary HMO benefits include limited coverage of ambulatory and institutional services for mental health problems and substance abuse, we believe that these will not sufficiently provide access to treatment for people with mental illness or promote mental wellness. We believe that coverage for mental health care should be comparable to that for physical health care. Comprehensive mental health benefits would prevent inappropriate "substitution" of general medical services and promote patient access to alternatives to institutionalization. It would also lead to better use of resources in the health care system by establishing incentives for early, less-costly care.

**Cost-sharing.** Modest premiums and cost-sharing requirements encourage individuals to use less health services. However, cost-sharing can cause inappropriate delays in care that can lead to more serious medical problems and higher treatment costs. Therefore, premium and cost-sharing requirements must be set very carefully to avoid establishing barriers to needed health care.

For the poor and other low and moderate-income individuals, cost-sharing can limit access to health care services dramatically. There is clear evidence that the health of poor people deteriorates if they are required to pay, even partially, for their medical care. Moreover, delaying care can increase total health care costs by substituting more expensive emergency care for less expensive care in a physician's office.

To contain overall program costs, cost-sharing rules should avoid perverse incentives to receive health services in inappropriate or unnecessarily costly settings. For example, cost-sharing for physician office visits that is excessive or not on a par with other ambulatory care settings may make hospital emergency rooms a financially preferred alternative for receiving services.

It is essential that any cost-sharing structure include limits on a consumer's out-of-pocket liability. Those limits should be sensitive to differences in individual ability to pay and should take into account consumer contributions to both premiums and cost-sharing. This would help overcome the persistent financial barriers to access that are highly undesirable and too common in our current system.

**New Medical Technology.** Development of a standard benefits package will need to address the rapid changes in medical procedures. New health care technologies, and improvements in existing technology are a major reason this country's health care system is so admired. Unfortunately, they are also one of the major forces driving cost growth in our existing delivery system.

In a reformed health care system, we must find the way to support technology's development and improvement while assuring that new and existing technologies are used both effectively and efficiently. AARP believes that this can best be accomplished in a reformed health care system through coordinated efforts at both the national and state levels.

First, all technology assessment should be centralized in a national board which has both scientific -- and policy -- assessment responsibilities. We believe this national agency's technology assessment program must rely on sound clinical knowledge. It is this board which would judge whether improved or new technologies are both effective and efficient, and whether they would be included in the coverage provided under a standard benefits package.

Second, all decisions about whether costly new or improved technology is to be acquired, no matter who might wish to make the purchase, should be made at the state level. A state entity would be charged with the responsibility of assuring that decisions to place technology into service incorporate consideration of both medical and economic efficiencies.

Payments rules and rates for these new technologies should be established in coordination with coverage decisions and need to be re-assessed over time. The cost of a new procedure may even decrease as it becomes more widespread or as other procedures take its place. For example, the cost of cataract procedures decreased in the 1980's due to greater efficiencies, and Congress responded by reducing Medicare provider payment rates.

AARP believes that only through a comprehensive, nationally-applied program of technology assessment can we be assured of the addition of both high quality, and cost-effective, technologies to the health care benefits available to all in the U.S.

**Long-Term Care Benefits.** A comprehensive benefits package must include coverage of long-term care services. In order to function optimally in society, persons of all ages who have disabilities often require a broad range of services, determined by individual need. An adequate package of services should include nursing, personal care, rehabilitative and restorative care, homemaker services, respite care, adult day care, transportation, minor home adaptations, and other services, as needed. These services should be available regardless of where the individual resides: at home; in an assisted living facility; or in a nursing facility. While services in all residential settings should be included in a comprehensive program, elimination of the institutional bias that exists in the current long-term care system is critical.

Truly comprehensive health care reform must provide for a full continuum of health services over a person's life span. To a family, there is no difference between spending \$30,000 on hospital care and spending \$30,000 on nursing home care. A proposal that fails to integrate care needs in a seamless web will not work.

Because the cost of long-term care is prohibitively expensive for most Americans, it is critical that financial protection mechanisms make the receipt of care affordable. In general, people fear having their savings wiped out, should they or a family member require nursing home care. Moreover, because the current system has inadequate provisions for alternatives to nursing homes, such as home care or care in assisted living facilities, costly nursing home care is often seen as the only place in which assistance may be received.

Services must be made affordable to persons of all income levels. Reasonable cost-sharing is an appropriate mechanism to instill a sense of contribution to the program and to discourage inappropriate use of services. However, financial protection for people with low and moderate incomes is essential.

The principal cost-sharing mechanism for long-term care in AARP's Health Care America proposal is to require copayments for services received. As with the receipt of medical services, regardless of their cost, there is no asset test. AARP believes that this is consistent with the principle of social insurance -- all individuals contribute to the system, and all should be entitled to benefits when needed, without having to deplete their life savings.

Some have proposed leaving long-term care to the private insurance market. There are a number of reasons why individually-purchased private long-term care insurance will not and cannot be a viable solution for most people. Long-term care insurance premiums tend to be steep -- especially for policies with meaningful benefits that keep pace with inflation. In addition, underwriting restrictions leave persons with disabilities or a poor medical history unable to obtain coverage. Even with the improvements of the past several years, most of the policies on the market today, have restrictions and exclusions that limit their effectiveness.

#### **Who Will Determine The Standard Benefits Package?**

The debate over the standard benefit package will be intense. The pressure to include or exclude certain services will be enormous. The participation of so many groups in today's hearing is a clear message that the benefit package is a central element of health care reform and all Americans have a major interest in getting it right. However heated the debate may be in Congress, this is one area in which heat will shed light on the hard



choices that must be made. And this light is needed to establish a package that is fair and accountable to the public. To ensure this accountability, Congress and the President should make the critical decisions about benefits themselves and not leave them to the backrooms of an as-yet-to-be-named board or commission. If fine-tuning and ongoing review of the benefits package is delegated to boards or commissions at the federal and state levels, then it is essential that the public control these bodies and make the decisions accountable to the people.

#### The Cost Implications of A Comprehensive Benefits Package

While a guaranteed comprehensive benefits package will reduce health care users' out-of-pocket costs and make health care more equitable, it will require additional resources from the federal government, businesses, and some individuals. Some businesses and individuals with less coverage now will pay higher premiums for a higher level of benefits. Additional federal funding will be needed to expand benefits to Medicare and Medicaid populations and to subsidize care for other individuals who are without adequate employer coverage. Some of this funding could come from health care providers or insurers who will benefit from reduced cost shifting from uninsured and underinsured individuals. But additional sources of funding will be needed. AARP firmly believes that this need for additional federal funding, however difficult to discuss, must be an integral part of the debate over a standard benefits package if we are to see genuine health care reform.

While a comprehensive benefits package will require additional federal funding, it will also be a critical factor in successful health care cost containment. If coverage for long-term care, prescription drugs, mental health or other health care needs is left outside the standard benefits package, cost shifting between what is covered and what is not would occur and seriously compromise any system-wide cost containment efforts. Trying to enforce national spending targets would be like the proverbial "squeezing one end of the balloon."

#### Conclusion

This is the first of what will certainly be a lengthy series of hearings this year by this and other committees around the challenges of health care reform. You have begun today to address one of the twin problems in our health care system -- that is, the health coverage needs of Americans. We look forward to subsequent hearings and discussion on the problem of health care costs.

I hope our testimony today will contribute to your discussions on health care reform. We welcome any questions the subcommittee might have.

Chairman STARK. Thank you, Mr. Lehrmann.  
Ms. McSteen.

**STATEMENT OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE**

Ms. McSTEEN. Mr. Chairman and members of the subcommittee, I am president of the National Committee to Preserve Social Security and Medicare.

The United States cannot reform its health care system without greatly affecting the system's largest user, those age 65 and over. Medicare is viewed by National Committee members as a good program. While most seniors agree that Medicare is an invaluable program, it does have very significant coverage gaps.

At a time when the average annual senior's income is little more than \$15,000, Medicare leaves seniors having to pay an average of \$3,305 out of pocket each year for health care. Much of that is for expenses related to prescription drugs, long-term care, and preventive care services which Medicare does not cover. These additional costs are seniors' biggest concerns and, therefore, any national health care reform worthy of the name must effectively deal with them.

I would like to address very briefly four needed benefits: outpatient prescription drugs, long-term care, preventive health care, and limits on total out-of-pocket costs.

First, prescription drugs: For American seniors, prescription drug costs are a problem that must be cured by inclusion in the standard benefit package. A recent poll of National Committee members shows medications are their single largest out-of-pocket health care expense. Among our members with yearly out-of-pocket drug costs of \$1,000 or more, one-fourth have annual incomes of less than \$15,000.

Low incomes and high drug bills too often result in adverse reactions from medication noncompliance and needless hospitalization, according to a 1991 Institute of Medicine study. If these seniors did not have to be admitted to the hospital, Medicare could save \$4 to \$10 billion.

Second, long-term care: The awesome financial burden of long-term care for chronic conditions threatens citizens, their spouses and families with bankruptcy. In a nationwide survey of the general public conducted for the National Committee, 7 out of 10 respondents said they could not afford the cost of nursing home care, if a family member really needed it.

We recommend that long-term care begin with home and community-based care, including adult day-care. Over time, a wide spectrum of benefits should include rehabilitative services, institutional care, respite care for care givers, assisted living and other housing options, and transportation.

Third, the preventive health care: The lack of such care under Medicare has been a major concern for National Committee members. We also know that it has been a source of concern and frustration to you, Mr. Chairman, and to members of your subcommittee.

The National Committee applauds your efforts in enacting a mammography screening benefit for older women and for your at-

tempts in gaining passage of a colorectal screening benefit under Medicare.

The National Committee recommends that the standard benefits package include preventive services such as immunizations, health screenings and health education. And lastly, seniors and all Americans need to be shielded from catastrophic health care costs. Most private insurance plans currently contain out-of-pocket limits beyond which the plan pays 100 percent of the cost. No health care reform package would be complete without a reasonable limit on out-of-pocket costs.

The National Committee further recommends that special out-of-pocket limits be established for the near-poor and those below the poverty line.

In conclusion, the National Committee believes that benefits should be standardized and universally applied, so that every American is offered the same basic benefits package. The package must be comprehensive, or those with serious health care needs, especially older Americans, will be penalized.

We applaud the administration's leadership and resolve to present a health care plan for all Americans in the administration's first 100 days.

Thank you, Mr. Chairman.

[The prepared statement follows:]





**Statement of Martha McSteen**  
**President**  
**National Committee to Preserve Social Security and Medicare**  
**Submitted to**  
**Subcommittee on Health**  
**House Committee on Ways and Means**  
**Regarding**  
**Health Care Reform Standard Benefits Package**  
**March 30, 1993**

Mr. Chairman, Members of the Subcommittee, my name is Martha McSteen, and I am president of the National Committee to Preserve Social Security and Medicare. The National Committee represents approximately six million members and supporters who are vitally interested in the contents of the "standard" benefit package being considered by this Subcommittee, the Congress and the Administration. The National Committee welcomes the opportunity to testify before your subcommittee today to share its thoughts on this critical topic.

The United States cannot reform its health care system without greatly affecting the system's biggest users: those aged 65 and over. Medicare is viewed by National Committee members as a good program. While most seniors agree that Medicare is an invaluable program, it does have very significant coverage gaps. At a time when the average annual senior's income is little more than \$15,000, Medicare leaves seniors having to pay an average of \$3,305 out of pocket each year for health care, according to a recent Families USA study. Much of that is for expenses related to prescription drugs, long-term care and preventive care services which Medicare does not cover. These additional costs are seniors' biggest concerns and therefore any national health care reform worthy of the name must effectively deal with them.

As a result, the National Committee recommends that the "standard" benefit package include:

- Outpatient prescription drugs
- Long term care
- Preventive health care and
- Limits on total out-of-pocket costs.

The National Committee also believes that all current Medicare benefits should be included in the "standard" benefit package and that Medicare should be expanded to include the above mentioned benefits. In other words, Medicare and the benefits package included in national health care reform should be identical. In this way all Americans will enjoy the same health care coverage.

### **Prescription Drugs**

For American seniors, prescription drug costs represent an almost universal Achilles' heel which must be cured by inclusion in the standard benefit package.

In recent years, prescription drug price increases have outstripped inflation by three fold. At the same time, seniors need more prescriptions than those under age 65 and often have little or no insurance to cover the cost. A recent poll of National Committee members shows medications are their single largest out-of-pocket health care expense. Among our members, with yearly out-of-pocket drug costs of \$1,000 or more, one-fourth have annual incomes of less than \$15,000.

Low incomes and high drug bills too often result in adverse reactions from medication non-compliance and needless hospitalization, according to a 1991 Institute of Medicine study. If these seniors did not have to be admitted to the hospital, Medicare could save \$4-10 billion.

### **Long-Term Care**

Long term care coverage must also be included in any standard benefit package. Although seniors understand that the cost of this benefit may make it necessary to phase it in over a longer period of time than some other benefits.

The awesome financial burden of long-term care for chronic conditions threatens seniors, their spouses and families with bankruptcy. In a nationwide survey of the general public conducted for the National Committee, seven out of

ten respondents said they could not afford the cost of nursing home care if a family member needed it. Nursing home care costs an average of \$25,000 to \$35,000 per year. Few Americans have any protection from this kind of expense. And, according to Consumers Union, none of the long term care insurance policies currently on the market provide adequate protection.

Understanding the cost implications of a long term care benefit and based on a survey of our members, we recommend that long term care begin with home and community based care, including adult day care. Over time, a wide spectrum of benefits should include rehabilitative services, institutional care, respite care for caregivers, assisted living and other housing options and transportation. To contain costs, long-term care benefits should be delivered through a care management system with set rates for services and overall set budgets.

Eventually, the National Committee would like to see a continuum of care bridging the gap between acute and long-term care. As a beginning, we recommend an expansion of programs such as the Social Health Maintenance Organizations (SHMOs) and the Program of All-Inclusive Care for the Elderly (PACE).

### **Preventive Health Care**

The lack of preventive health care benefits under Medicare has been a major concern of National Committee members. We also know that it has been a source of concern and frustration to you Mr. Chairman and to members of your Subcommittee. The National Committee applauds your efforts in enacting a mammography screening benefit for older women and for your attempts in gaining passage of a colorectal screening benefit under Medicare. There are a number of preventive care services that could avert both human and financial costs if they were included as Medicare benefits. The National Committee recommends that the standard benefit package include the following preventive services: (1) immunizations, (2) preventive health screenings as appropriate, and (3) health education for patients on the management of chronic diseases such as diabetes, where cost effectiveness has been demonstrated.

### **Limits on Total Out-of-Pocket Expenses**

Lastly, seniors and all Americans need to be shielded from catastrophic health care costs. Most private insurance plans currently contain out-of-pocket limits beyond which the plans pay 100% of the cost. No health care reform package would be complete without a reasonable limit on out-of-pocket costs. The National Committee further recommends that special out-of-pocket limits be established for the near poor and for those below the poverty line.

### **The Benefits of Standardization**

Our organization believes that benefits should be standardized and universally applied so that every American is offered the same basic benefit package. The package must be comprehensive, or those with serious health care needs - especially older Americans - will be penalized.

### **Conclusion**

Again, thank you for the opportunity to testify before the Health Subcommittee. In designing a standard benefit package, policy makers should remember that one of the goals of health care reform is to assure all Americans access to needed medical care.

Americans should be free from the fear of impoverishment from high prescription drug bills or long term care costs and limits must be placed on overall out-of-pocket health care expenses. Preventive care must also be included in the continuum of care benefits.

Chairman STARK. Thank you.  
Ms. Kolker.

**STATEMENT OF ANN KOLKER, DIRECTOR OF PUBLIC POLICY/  
HEALTH AND REPRODUCTIVE RIGHTS, NATIONAL WOMEN'S  
LAW CENTER**

Ms. KOLKER. Mr. Chairman and members of the subcommittee, I am Ann Kolker, director of public policy for health and reproductive rights at the National Women's Law Center. I appreciate the opportunity to appear before you today.

I would like to add that the Women's Legal Defense Fund supports the thrust of our remarks, and I believe that other pro-choice organizations will be submitting in writing or appearing before the committee with statements which echo the thrust of our remarks, as well.

We are pleased to be appearing with the Campaign for Women's Health, which we have worked with closely since its inception. We serve on the Campaign's executive committee and established the Campaign's legislative task force.

As this committee considers fundamental changes in the health care system, the health care needs of all Americans, including women, must be addressed. Our statement today focuses on one aspect of basic health care which is critical to include in a core benefits package, reproductive health.

Reproductive health is an essential component of the health care that women need throughout their lives. Not only is it essential for women's own health, but it confers benefits to a woman's children and her sexual partners. Because reproductive health care is so central to women, it is often the first type of care a woman seeks, and for many the only form of primary care she receives.

Reproductive health care services are also linked and inseparable, all provided by the same providers. This approach must be reflected in the core benefits package. We believe that a core benefits package must cover pregnancy, delivery and postnatal care, safe and effective contraception, infertility services, treatment for reproductive tract diseases and, of course, abortion services. And in addition to the basic health and hospital services which these services require, we believe that they also require education, counseling, diagnostic and screening services, as well as appropriate drugs and devices.

It is important for the committee to note that certain reproductive health care services, family planning, for example, are not provided in response to an illness or injury, but, rather, necessary to treat a condition—pregnancy or the desire to avert pregnancy. We bring this to the committee's attention, because the development of a benefits package often starts with the discussion of the standards that will be used to establish the parameters of the package.

We have seen two approaches commonly used: One, all legally authorized treatments for the maintenance of a health condition and a medically necessary standard. We prefer the broader standard, which covers many important health needs, and I believe the Campaign will elaborate on that.

If, however, the medically necessary standard is ultimately adopted, we urge the committee to clarify that it covers all preg-



nancy-related services that are treatments for conditions, not just illnesses or injury, or that reproductive and preventive services are exempt from the medically necessary standard.

Let me spend a minute detailing why the services are so critically important.

**First, family planning:** For the decades that span adolescence to menopause, women require access to family planning services, because for 90 percent of her reproductive life, the average woman is trying either to postpone giving birth or to avoid having more children.

**Abortion:** All women need access to safe, legal pregnancy termination services, and abortion must be a covered service in the core benefits package. Abortion, as is well known, is extremely safe. Indeed, the American Medical Association reports that the mortality rate from childbirth is more than 10 times as high as the mortality rate from abortion.

**Prenatal and maternity care:** The enormous benefits of early and comprehensive prenatal and maternity care have been well-documented, and the high correlation between the absence of prenatal care and poor birth outcomes which result in costly treatment alone underscores the importance of including this health service.

**STDs and reproductive tract diseases:** Detection, treatment, and prevention of STDs and reproductive tract diseases must also be included in the package. Each year, more than 12 million women contract an STD, and we know that inattention to these conditions and diseases again results in very high-cost treatments down the line and impairs the health of women and their partners.

**Infertility services:** Infertility is a treatable and curable disease and it must also be included in the core benefit package. Over 2 million couples struggle with the disease of infertility and it is a treatable condition.

We believe that it is critical that the package also attend to the unique and special needs of substance abusing pregnant women who have difficulty finding treatment facilities that will accept them, and then when they do finally find the facilities, they must be assured that their treatments will be reimbursed.

I would like to conclude by just sharing with you some of the experience that both private health insurance plans—both indemnity plans as well as HMOs—as well as public health programs, have in providing models for coverage of these reproductive health care services.

For example, Government health programs have led the way in recognizing the importance of family planning services. Medicaid, for example, provides a favorable 90 percent match rate for family planning services. All 50 States have opted to provide Medicaid coverage for Norplant. Of course, we know that the Government has one program, title X, which is devoted exclusively to the provision of family planning services which is on track for reauthorization, after 7 years of being held up by the extremists.

Private health insurance generally covers abortion services. In some cases, the policy explicitly covers abortion. Often, however, the procedure is covered in the same manner that pregnancy is covered. Some plans describe pregnancy as an illness and state that pregnancy will be covered as any other illness. Others, it appears,

make a practice of reimbursing for abortion under the general rubric of covering medically necessary services.

The only State with universal health insurance, Hawaii, provides coverage for abortion services and could serve as a model for Federal policymakers on this and other important issues.

This committee knows well the commitment that the Federal Government has made on the issue of prenatal care. It is a priority in public health programs, and we see as a result of the Pregnancy Discrimination Act that all employers are required to provide prenatal and maternity care services in the same way that they provide services for other health conditions.

On the provision of infertility services, States have led the way. Ten States currently require insurance companies to cover infertility services, and I believe HIAA estimates that about 40 percent of people covered by private insurance have some coverage for services related to infertility.

This concludes my remarks. We look forward to working with the committee to insure that these benefits are included in the core package and to help you work out the details of how best to include them.

Thank you.

[The prepared statement follows:]

TESTIMONY OF ANN KOLKER  
 NATIONAL WOMEN'S LAW CENTER  
 BEFORE THE SUBCOMMITTEE ON HEALTH,  
 COMMITTEE ON WAYS AND MEANS  
 U.S. HOUSE OF REPRESENTATIVES  
 ON  
 HEALTH CARE REFORM:  
 CONSIDERATION OF BENEFITS FOR INCLUSION IN A  
 STANDARD HEALTH BENEFIT PACKAGE

Mr. Chairman and members of the Subcommittee, I am Ann Kolker, Director of Public Policy/Health and Reproductive Rights at the National Women's Law Center. I appreciate the opportunity to appear before you today, on behalf of the National Women's Law Center. The Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including health care reform, reproductive rights, employment, dependent care, education, income support and tax reform -- with special attention given to the concerns of low-income women and children.

We are pleased to be appearing with The Campaign for Women's Health - which we have worked with very closely since its inception. We serve on The Campaign's Executive Committee and established the Campaign's Legislative Task Force which has health reform as its major priority.

National health care reform is of major concern and priority of American women. As this Committee considers fundamental change in the health care system, the health care needs of all Americans, including women must addressed. In addition to ensuring that the system be designed to provide universal access, comprehensive coverage, and cost-effective and affordable care, any reform proposal must also include a core benefits package that meets basic health care needs. Our testimony today focuses on one aspect of basic health care which is essential to include in such a package - reproductive health.

#### I. PROBLEMS WITH CURRENT COVERAGE

The core benefit package is a critical component of the entire health reform system since these benefits will set the level of care individuals and families will actually receive. If the benefits package is too thin, we will perpetuate problems which plague our country now - too many who are denied critical health care because they cannot afford its cost. Key services not in a core benefits package will again be unavailable to those with limited means.

The stakes for women in the contours of the benefits package are especially high, because women are particularly disadvantaged under our current health care system. Women and their children are disproportionately represented among the uninsured with 12 million American women currently lacking health insurance of any kind. While 56% of employed men have health insurance coverage through work, a mere 37% of employed women have employment-based health insurance. This wide disparity results from several factors. First, there is a high concentration of women in service and retail jobs, which have low rates of employer-provided insurance. Secondly, women are in the highly vulnerable position of receiving dependent coverage; they comprise 73% of those who receive employer-based coverage as dependents - where employer cut-backs have been harsh in recent years. Finally, women are more likely to receive publicly financed health



coverage. Of all individuals receiving publicly funded health care, 61.6% are women.

Absence of health care coverage has devastating consequences for women's overall health, denying them access to vital treatments or forcing them to skip prenatal care while pregnant. Furthermore, the failure of our health care delivery system to serve poor and rural areas takes a serious toll on many women and their children, especially pregnant women and newborns. Even when available, care for preventive services are often not covered services, putting routine check-ups and screening tests such as mammography and pap smears, out of reach for many women.

Ironically, even when they have health insurance coverage, basic reproductive health needs of women are met by a patchwork of public and private insurance models with no underlying scheme or rationale. Private health insurance plans, for example, offer substantial experience in covering abortion services, yet they sometimes fail to provide coverage for contraceptives or infertility services. In contrast, public programs provide substantial pre-natal, maternal and family planning services to low-income women yet restrict coverage of abortions. In addition, many publicly funded programs and, often, private insurance plans fail to cover Pap smears, yet those same programs pay for expensive procedures once cervical cancer is diagnosed. Sadly, in other instances, vital reproductive health care services such as family planning and abortion have been restricted by policy makers bowing to pressure from right wing extremists. The uneven way private insurance and public programs cover reproductive health care services underscores the importance of developing a national reform package which covers all necessary reproductive health care services. They must be treated as part of a continuum and available to individuals without distinctions based on income or place of residence.

## II. REPRODUCTIVE HEALTH CARE SERVICES

Reproductive health is a critical component of the health care women need throughout their lifetime. Not only is it essential for women's own health but it confers health benefits to a woman's children and sexual partners. Because reproductive health care is so central to women, it is often the first type of care a woman seeks, and for many the only form of primary care she receives.

Reproductive health services are also linked and inseparable. For example, the safe and effective use of contraceptives can greatly enhance women's health by enabling them to space or limit their births. Likewise, the health of both a pregnant woman and her baby as well as her sexual partners can be severely compromised by reproductive tract infections and sexually-transmitted diseases that are left unchecked and untreated. Both women and their health care providers view reproductive health services as part of a continuum, and this approach must be reflected in the core benefits package.

At a minimum, a core benefits package must cover all reproductive health needs. A women's reproductive health care includes pregnancy, delivery and post-natal care; safe and effective contraception; infertility services; treatment for reproductive tract diseases, which are the leading contributors to conditions such as infertility and cancer; and abortion. In addition to the obvious physician and hospital services which these procedures require, the benefits package must ensure coverage of the requisite and appropriate prevention, diagnostic, screening and education services, as well as drugs and devices which are critical to maintaining a healthy reproductive system.

It is important for the Committee to note that certain reproductive health care services, family planning for example, are not provided in response to an illness or injury - but rather necessary to treat a condition: pregnancy or the desire to avert pregnancy. We bring this to the Committee's attention because the development of the benefits package often starts with a discussion of the standard that will be used to establish the parameters of the package. The two approaches that we have seen most often are a broad based standard which allows "all legally authorized treatments for the maintenance of a health condition" and a "medically necessary" standard. We prefer the broader standard which covers many important health needs. If, however, the "medically necessary" standard is ultimately adopted, we urge the Committee to clarify that it covers all pregnancy-related services that are treatments for conditions, not illnesses or injuries, or that these services are exempt from the standard.

I will now briefly address the various reproductive health services that we believe must be included in a core benefits package.

### 1. Family Planning.

**Family planning services**, including access to contraceptive care, are essential to women's health and accordingly must be a covered service. For the decades that span adolescence to menopause, women require access to family planning services including safe and effective contraceptive methods. For 90 percent of her reproductive life, the average woman is trying either to postpone giving birth or to avoid having more births; for only ten percent of her reproductive life is a woman actually pregnant or attempting to become pregnant. Effective family planning services and contraceptive care improves the health of women by assisting them avert unintentional pregnancies, space their children and reduce the need for abortions. Furthermore, contraceptive methods can assist women and their partners in preventing transmission of sexually transmitted diseases.

### 2. Abortion.

As all women need access to safe, legal pregnancy termination services, **abortion** must be a covered service in the core benefits package. Abortion is a safe and effective procedure to terminate an unwanted pregnancy, especially when performed early in pregnancy when 90% of the abortions are done. Indeed, it is far safer than childbirth. Moreover, the legalization of abortion, coupled with improvements in medical technology and the trend toward earlier terminations have made abortions even safer. The AMA reports that the mortality rate from childbirth is more than ten times as high as the death rate from abortions. Further, the risk of serious complications from a legal abortion is also low, and most women who have an abortion experience few if any problems getting pregnant or having healthy children in the future. Safe abortion services depend on the ability of a woman to have early access to a physician or other health professional who provides abortion services.

### 3. Prenatal and Maternity Care.

The enormous benefits of early and comprehensive **prenatal and maternity care** for maternal and child health are well-documented and consequently must be covered in any standard benefits package. Prenatal care that begins early and continues throughout pregnancy can prevent low birthweight babies as well as infant mortality. Infants born to mothers who receive inadequate care are significantly more likely to die in infancy or be left with lifelong disabilities. According to a study by the Alan Guttmacher Institute, the infant mortality rate is 9.7 per 1,000 live births among newborns whose mother began prenatal

care in the first trimester. It rises to 12.5 per 1,000 where care was initiated later in pregnancy. And it jumps to 48.7 per 1,000 cases where the mother obtained no prenatal care at all. The high correlation between the absence of prenatal care and poor birth outcomes alone underscores the importance of this health service.

#### **4. STDs and Reproductive Tract Diseases.**

Detection, treatment and prevention of **sexually transmitted and reproductive tract diseases** must also be included in the benefits package. Each year more than 12 million women contract a sexually transmitted disease ("STD"). Inattention to these often treatable diseases can lead to pelvic inflammatory disease, infertility, cancer, ectopic pregnancy, infant pneumonia and death, mental retardation, immune deficiencies and the death of infected individuals. The health risks of these diseases multiply when, undetected and untreated, STDs are passed on by a woman to her sexual partner or by a pregnant woman to her unborn child.

Women's lives are also threatened by reproductive tract diseases such as cervical cancer. The diagnosis of invasive cervical cancer cases represents missed opportunities at screening, early diagnosis and treatment. If women received regular Pap smears and diagnostic colposcopies when indicated, the incidence of death from cervical cancer would be significantly reduced if not eradicated. Unfortunately, the well-documented bias against diagnostic and preventive care in both our public and private health insurance programs has left many individuals without access to the screening and early detection services that are so essential to treat and stem the spread of reproductive tract and sexually transmitted diseases. Unchecked or undiagnosed, these diseases become more serious, necessitating high cost medical procedures, and/or resulting in unnecessary health impairment. The benefits package must assure coverage for preventive health care screening and services for both women and men to ensure that reproductive tract diseases are promptly diagnosed and adequately treated.

#### **5. Infertility Services.**

**Infertility**, a treatable and curable disease, must also be included in the core benefit package. Over 2.3 million couples struggle with the disease of infertility and one in every six couples is infertile or fails to conceive within a year of deciding to have a child. Infertility is a treatable reproductive disease with 50% of infertile people treated able to achieve a pregnancy. Each year, close to one million couples seek medical advice or treatment for infertility. Women and men both need and are entitled to receive health care coverage for basic infertility diagnostic and treatment services.

#### **6. Special Needs of Substance Abusing Pregnant Women.**

Finally, the standard benefits package must include coverage for the special treatment needs of substance abusing pregnant women, HIV-infected and battered and abused women. Substance abusing pregnant women frequently find it difficult to locate drug treatment facilities which will accept them, and when they do, they must be confident that their necessary treatment will be re-imbursed. Furthermore, health care specialists have only recently begun to recognize the important role that they have in treating abuse and battery as medical problems and these services must be reimbursed.



## **7. Elimination of Co-Payments and Deductibles.**

A benefits package must also encourage the use of preventive care services by eliminating or reducing deductibles and co-payments for these services. Preventive services run the gamut from routine check-ups for pregnant women, to diagnostic and screening services such as mammography and pap smears, and to well baby care. Family planning must be considered in this category, as many private health insurers have recently begun to do.

## **8. Cost-Effectiveness.**

Including the full panoply of reproductive health care services in a comprehensive benefits package is also cost effective. For example, every dollar spent on prenatal care saves \$3.38 in the cost of caring for low birth weight babies. Averting one low birth weight baby can save \$14,000 - \$30,000 in first year hospital and long-term health care costs. Family planning is equally cost effective; for every \$1.00 invested in public family planning services \$4.40 are saved. Furthermore, prevention and early treatment of sexually transmitted diseases saves millions of dollars in direct health care costs and millions more in the indirect costs of low wages and decreased productivity of affected women. In 1991, gonorrhea and chlamydia screening and education saved as much as \$193.1 million in direct health care costs and as much as \$153 million in indirect costs.

## **III. MODELS FROM PRIVATE INSURANCE AND PUBLIC HEALTH PROGRAMS**

Experience from private health insurance - indemnity and Health Maintenance Organization plans (HMOs) - as well as from public health programs provides models for the coverage of these reproductive health care services. For example, government health programs have led the way in recognizing the importance of family planning services. Medicaid for example, provides a favorable 90% match rate for family planning services; all 50 states have opted to provide coverage for Norplant, and of course, the federal government devotes one program, Title X solely to family planning, which appears on track for reauthorization after over seven years of being held up by extremists.

Private health insurance generally covers abortion services. In some cases, the policy explicitly covers abortion. Often, however, the procedure is covered in the same manner that pregnancy is covered. Some plans describe pregnancy as "an illness" and state that pregnancy will be covered as any other illness; others, it appears, make a practice of reimbursing for abortion under their general rubric of covering medically necessary services. The only state with universal health insurance - Hawaii - provides coverage for abortion services - and could serve as a model for federal policy makers on this and other important issues.

Fortunately as a result of the commitment of many on this Committee and others in Congress, pre-natal care is a priority in public health programs - as evidenced by the enhanced services available to pregnant women receiving Medicaid - and the support given through other programs such as the maternal and child health block grant. Private coverage for maternity care has also come a long way in recent years, largely due to the Pregnancy Discrimination Act which requires employers to treat pregnancy as they treat other disabilities, for health insurance and other purposes. However, even with these well-intentioned policies, many women "fall through the cracks" and fail to get maternity coverage through either Medicaid or a private insurance plan.

On the provision of infertility services, states have led the way. Currently ten states require insurance companies to cover infertility services, and the Health Insurance Association of America estimates that 40% of people covered by private insurance have coverage for some services related to infertility.

\* \* \* \* \*

Mr. Chairman, in conclusion, it is essential for our nation's health that we develop a comprehensive health care system which fully meets the entire spectrum of reproductive health needs of women. In addition to assuring affordable, universal access, any new health care reform scheme must require a benefits package which covers all women's reproductive health needs - from pre-natal and maternity to family planning, contraception, infertility and abortion care. Further, the plan must include coverage for preventive care that runs the gamut from routine check-ups for pregnant women, to diagnostic and screening services such as pap smears, to family planning services. Our nation's health depends on it.

Chairman STARK. Thank you very much.  
Ms. Kuriansky.

**STATEMENT OF JOAN A. KURIANSKY, CHAIR, THE CAMPAIGN FOR WOMEN'S HEALTH AND EXECUTIVE DIRECTOR, OLDER WOMEN'S LEAGUE**

Ms. KURIANSKY. Thank you, Chairman Stark and distinguished members of the subcommittee.

I am Joan Kuriansky, executive director of the Older Women's League and chair of the Campaign for Women's Health. The Campaign is a broad coalition of 75 organizations representing 8 million people in this country who are committed to insuring that women's health concerns are addressed in health reform.

There are, as you know, a series of social, biological, and economic factors which impede women's health access. Particularly relevant to this discussion on benefits is that which is described by the Public Health Service in 1983, which identified women's health as conditions which are unique to women, conditions and diseases which affect women differently, and those that have a disproportionate impact on women.

To fully address these differences, particular treatments and services must be incorporated into a comprehensive benefits package. Before I go into the details of that package, I want to say that, of course, benefits become meaningless without access, and it is because of that, that the Campaign for Women's Health stands clearly on the side of creating a single tier of care that is not tied to employment or marital status, and we want that care to be reflective of women's needs from the beginning of their lives through the end of their lives.

Regardless of which entity is ultimately responsible for defining specific benefits within a plan, we think it is very important that the threshold benefit standard be carefully crafted and reflect the commitment to a standard which actively promotes good health and not only responds to illness.

For those reasons, the Campaign urges the adoption of a standard which includes all services which are necessary or appropriate for the maintenance and promotion of health, including women's health.

Medically necessary services have traditionally been defined as those which treat illnesses, disease, accident or disability. Defining a benefits package solely on the basis of medically necessary services could contradict the goal of comprehensive health reform, and in some instances impede the provisions of preventive services, a full range of reproductive services and long-term care, all of which are essential components of women's health.

The Campaign supports a system of preventive and primary care, which includes periodic histories and physical exams. The exams should include blood pressure checks, urinalysis, total blood and cholesterol tests and age-appropriate screenings for osteoporosis, dental health, vision, speech and hearing functions. Access to affordable prescription drugs and devices should also be included.

Also necessary are evaluations for nutrition, mental health, drug and substance abuse and harassment and violence prevention. Every 15 seconds, a woman is beaten in her own home. Studies



have shown that medical expenses are greater and physician visits more frequent for victimized women versus nonvictimized women, on a ratio of 2-to-1.

Women are the fastest growing population with HIV. Universal, anonymous HIV testing, with pretest and posttest counseling, will encourage more women to be tested and, thereby, save lives.

Primary and preventive reproductive health care services undergird women's health. My colleague, Ann Kolker, has testified on the nature of reproductive services to be included. I want to reinforce her testimony and make clear that it represents the interests of all of the Campaign members.

As executive director of an organization representing older women, I can assure you that our members are concerned about the right of a woman to stay in control throughout her entire life. Equally important is long-term care. For women, long-term care is a pivotal issue. We are most often the family care givers of the young, the old and the sick.

Like my colleagues from AARP and the National Committee, we believe that long-term care services include a continuum of services that should be offered in home, community, and institutional settings. We support a program with its first priority being the provision of home and community based services and protection from impoverishment for those families whose members must go into an institution. But we want to make clear that, from the onset, financial and administrative mechanisms must be put in place to assure a full range of services.

The delivery of health care must also be available in all different settings and by all different providers. We should be able to go to midwives, and if we choose, women practitioners.

Although it is unclear what kind of a benefits package will be established and who will develop that package, we want to make clear that accountability must be built into the system. That accountability must include consumers and women not defined as monolithic entities, but women representing different races, different incomes, different sexual orientation, and different ages.

With that, I will conclude my remarks. I look forward to working with you in the future.

Thank you.

[The prepared statement follows:]

## TESTIMONY OF JOAN A. KURIANSKY

Chair

The Campaign for Women's Health

before the

Subcommittee on Health

of the

House Ways &amp; Means Subcommittee

March 30, 1993

CHAIRMAN STARK AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to testify before your subcommittee today. I am Joan Kuriansky, Executive Director of the Older Women's League and Chair of the Campaign for Women's Health. On behalf of the Campaign, we applaud your efforts to address the issue of benefits, which are vital to women's concerns in health care reform.

The Campaign for Women's Health is a broad coalition of 75 national, state and grassroots organizations including women's groups, unions and health care organizations representing more than eight million individuals nationwide. An outgrowth of a women's health task force established in 1986 to monitor and respond to national health care initiatives, the Campaign convened in 1991 to ensure that women's needs are addressed in health care reform. Providing leadership, advocacy and public education, the Campaign strives to achieve a health care system which is sensitive to the needs of all women.

Women's requirements for health and well being have largely been ignored by the current health care system. Medical research, health care delivery and payment systems have failed to address women's changing needs. A series of social, biological and economic factors impede women's access to health care. Of particular relevance is the understanding that women's health concerns in some instances vary from that of others. In 1983, the Public Health Service described conditions that are unique to women conditions and diseases which affect women differently and those that have a disproportionate impact on women. To fully address these differences, particular treatments and services must be incorporated into a comprehensive benefits package.

A comprehensive benefits package is fundamental to women's interests in health care reform. Creating an appropriate standard under which a core benefits package is established is key to the success of the entire system. Based on a review of current and proposed qualifying language, the Campaign has adopted the following standard for the inclusion of benefits: **All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.**

We do not recommend the application of a medically necessary standard because we believe it is inconsistent with the promotion of good health. Health care is far more than merely the treatment of illness, disease, accident or disability. Defining a benefits package solely on the basis of medically necessary services could contradict the goal of comprehensive health reform and in some instances impede the provision of preventive services, a full range of reproductive services and long term care, all of which are essential components of women's health.

## **Primary and Preventive Care**

The Campaign for Women's Health supports a system of preventive and primary care which includes periodic history and physical exams. These exams should include blood pressure checks, urinalysis, total blood and cholesterol tests, and age-appropriate screenings for osteoporosis, dental health, vision, speech and hearing functions. Access to affordable prescription drugs and devices should also be included. Also necessary are evaluations for nutrition, mental health, drug and substance use, and harassment and violence prevention. Every 15 seconds a woman is beaten in her own home. Studies have shown that medical expenses are greater and physicians visits more frequent for victimized women versus non-victimized women on a ratio of 2:1. Routine domestic violence screening by health professionals, recently endorsed by the AMA but still uncommon, would not only improve the overall health of women but also lower the economic costs of treatment after the fact.

Another important component of primary and preventive care is anonymous testing and counseling for HIV. Women are the fastest growing population with HIV. The Centers for Disease Control (CDC) estimates that by 1995, 75,000 women will have AIDS as compared to 26,000 today. Studies by the CDC have shown that persons who are tested at anonymous test sites are more likely to seek additional care. Universal anonymous testing with pre-and post-test counseling will encourage more women to be tested and thereby may save lives.

## **Primary and Preventive Reproductive Health Care**

Reproductive health services are an inseparable part of primary and preventive services for women. The full complement of reproductive services are linked to one another and are an integral part of women's health and well being. Reproductive health services should comprise a continuum of services over the life course that precede, include, and follow the child bearing years. Regular gynecological history and periodic exams are essential primary care for women. A full range of maternity care services, including prenatal, intrapartum and postnatal care, are necessary to promote good health for both mother and child. Family planning services, evaluation and counseling for sexually transmitted diseases and menopause must also be included. Safe affordable abortions, associated with decline in maternal mortality, low birth weight infants and neonatal mortality, must be offered among the full range of reproductive services available to women.

## **Long Term Care**

Long term care is a woman's issue and a family issue. Women live an average of seven years longer than men and are more likely to suffer from chronic diseases. Women are also most often the family caregivers. A comprehensive benefits package that addresses women's needs must include a full range of long-term care services. The Campaign supports a program with its priority being the provision of home and community-based services and protection from impoverishment for those families whose members must go into an institution. Services should ultimately be available in all settings and support people with cognitive and mental impairments as well as those having difficulty with one or more ADL's or IADL's. While costs may initially prohibit the provision of a full range of services in all settings, the financing and administrative mechanism must be put in place at the outset.

## **Delivery of Health Care Services in a Variety of Settings & By a Range of Providers**

Lastly, the Campaign for Women's Health believes that women's health needs will be best served if health services are offered in a variety of settings and by a variety of providers.



Examples of cost effective settings which would increase access to affordable care include: community health, rural health and migrant health centers; public health and family planning clinics; school-based or -linked clinics; and allied health practitioners offices. Community-based care means primary, preventive and long term care would be more accessible and less costly than it is today.

Women should also have the option of care from the health care provider of their choice, including the choice of women providers. Providers should include not only physicians, but nurse practitioners, clinical nurse specialists, certified nurse midwives, lay midwives, licensed clinical social workers, optometrists, podiatrists, psychologists and other allied health practitioners. The ability to select from a variety of providers for care would provide care in a more efficient, affordable and coordinated manner than is currently available. Midwives are an example of alternative providers offering accessible, appropriate and cost-effective care to women. Working in a range of settings in the community, midwives offer maternity care services with a minimum of costly interventions. In addition, studies of midwifery care demonstrate that the care is equal to that of physician care, but that some morbidity rates are lower, surgical procedures are fewer and breastfeeding rates are higher.

### Summary

Although it is yet unclear what entity will develop a benefits package, accountability must be built in to the process. Women's health advocates representing women of different races and sexual orientations must be included on health boards, commissions or other regulatory bodies. Such a policy should be established by law. A comprehensive benefits package must be supported by a system which assures universal access to women and other American residents. Such access should not be tied to employment, marital status or ability to pay.

Health care reform offers a unique opportunity to redress many of the inequities women have faced in obtaining adequate health care for themselves and their families. The Campaign for Women's Health believes that a central step in achieving quality health care is to establish a comprehensive benefits package that includes primary and preventive care, reproductive health services, long term care, and services delivered in a range of settings by a variety of providers.

We are grateful to be given an opportunity to present this testimony today. We would like at this point to submit our Model Benefits Package for Women in Health Care Reform to the record. On behalf of the 52% of the population whose interests we represent, we thank you.

## A MODEL BENEFITS PACKAGE FOR WOMEN IN HEALTH CARE REFORM

### SUMMARY

The Campaign for Women's Health believes that health care reform must address the health needs of women. As 52% of the population, women are the major consumers of health services. Women are also the majority of health caregivers and the traditional caretakers of family health. Women's health is everyone's health.

A comprehensive benefits package is fundamental to women's interests in health care reform. All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.

Health care is far more than the treatment of illness, disease, accident or disability. In addition to hospital care and physicians services, women require a range of primary and preventive services from physicians and non-physician providers in a variety of settings. The following represent a comprehensive set of services, settings and providers -- beyond treatment of illness or disease -- for inclusion in a benefits package which will address women's health needs:

#### Primary and Preventive Care:

periodic history and physical exam,  
including blood pressure check,  
urinalysis, total blood cholesterol  
osteoporosis screen  
mental health screen  
domestic violence screen  
dental check  
vision check  
speech and hearing checks

prescription drugs and devices  
laboratory tests and immunizations as needed  
HIV counseling and anonymous  
testing  
evaluations for nutrition, exercise, mental health,  
tobacco use, drug and substance use,  
harassment/violence prevention,  
sexuality education and counseling

#### Primary and Preventive Reproductive Health Care:

periodic gynecological history and exam,  
including pelvic exam, Pap smear, clinical  
breast exam  
mammogram  
contraceptive drugs and devices  
maternity care  
prenatal  
labor and delivery  
complications of pregnancy and childbirth  
postnatal

counseling and services for:  
family planning  
abortion  
sterilization  
infertility  
sexually transmitted diseases  
gynecological infections  
menstrual disorders  
pregnancy  
menopause

#### Long Term Care:

chronic illness and disability care  
speech, physical and occupational  
therapy  
mental health care  
nutritional services  
home care services, equipment and  
supplies  
social support services

community support services  
prescription drugs and devices  
counseling for diet, exercise,  
injury prevention, tobacco use,  
drug and substance use, dental,  
violence, vision, speech and  
hearing care

#### Settings:

hospitals  
physicians' offices  
allied health practitioners' offices  
community and rural health centers  
specialized centers  
public health clinics  
school-based or -linked clinics

family planning clinics  
birthing centers  
skilled nursing centers  
long-term care facilities  
hospices  
home care  
respite care

#### Health Care Providers:

physicians  
physician assistants  
nurse practitioners  
clinical nurse specialists  
certified nurse midwives  
lay midwives  
licensed clinical social workers  
licensed allied health practitioners

optometrists  
podiatrists  
psychologists  
pharmacists  
physical, occupational, and language  
therapists  
home care workers and home health  
aides

## A MODEL BENEFITS PACKAGE FOR WOMEN IN HEALTH CARE REFORM

### Introduction

Health care reform offers an opportunity to redefine the dimensions of health and health care. While the public has understood for some time that health care is not the provision of medical services, the system has not. Currently our health system is quick to pay expensive bills for CAT scans, while it ignores the essentials of primary care, the cost-effectiveness of preventive care and the importance of long term care.

Creating an appropriate standard under which a core benefits package is established is key to the success of the entire system. Carefully reviewing current and proposed qualifying language, the Campaign established the following standard: **All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.**

We do not recommend the application of a medically necessary standard because we believe it is inconsistent with the promotion of good health. Although the term medically necessary is not yet defined in pending legislation, many earlier proposals applied the medically necessary standard embodied in Medicare. As defined by law, Medicare covers services necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body part.

Defining a benefits package solely on the basis of medically necessary services could contradict the goal of comprehensive health care reform and in some instances be contradictory to provision of preventive services, a full range of reproductive services including abortion, and long term care.

### Primary and Preventive Care

*The shift towards a cost-conscious health care system which prevents illness, disease and disability invites a strong emphasis on primary and preventive care for women. The majority of primary and preventive care services are low-cost, low-tech services which can be provided by a range of health practitioners in one-stop, out-patient settings. Most primary care services do not require a physician, other than for consultation and referral. The provision of the primary and preventive care services for women listed in this summary would address the majority of common health problems seen daily by primary care providers. Equally important, these same services also screen for cardiovascular and infectious diseases, cancers, injuries and the other major causes of death and disability in women.*

**Periodic History and Physical Exam, Including Blood Pressure Check, Urinalysis and Cholesterol Screen.** Personal health history and family history are reviewed to predict which patients are at risk for disease. Screens for common diseases such as diabetes and hypertension prolong life and are cost-effective. A full physical exam also includes an eye exam, thyroid evaluation and urinalysis. Blood pressure and weight checks as well as cholesterol screening evaluate the patient for cardiovascular disease, the leading cause of death for American women. Evaluations for nutrition, tobacco use, exercise, drug and substance use and violence, as well as mental health status, are completed. **Regular, periodic primary care visits provide the most important assessment of health status.**

**Osteoporosis.** Osteoporosis is a major cause of death and disability in women. It is a preventable, progressive disease which afflicts 50% of women over the age of 45 and 90% of women over 75. This bone-thinning disease results in 1.3 million



fractures each year and over 50,000 deaths, costing an estimated \$7-10 billion annually. *Yet, the disease is largely preventable by alerting younger women to the importance of dietary changes, weight-bearing exercise and calcium.* In women over age 35 bone loss may be arrested with a combination of diet, exercise, calcium supplements and, in high risk women, with estrogen replacement therapy and other treatments.

**Mental Health Screen.** Women suffer twice the rate of clinical depression as men. However, three-quarters of American women who experience clinical symptoms of depression never receive treatment. Some forms of anxiety disorder are also more common in women. An overwhelming percentage (90%) of eating disorders occur in women. And, in general, women's experience of mental illness differs from that of men, requiring appropriate screening and treatment. Over 20% of primary health care visits are mental health related. The American Psychological Association states that parity of mental health benefits with medical/surgical benefits is cost effective. *Routine mental health screening for women would ensure improved detection of mental illness in its earliest stages.*

**Domestic Violence.** Every 15 seconds an American woman is beaten in her own home. Women are twice as likely to be injured by violence as to be diagnosed with cancer. Battering is the single major cause of emergency room visits by women. The health consequences of violence against women result not only in bruises, broken bones, infection and disease but, in long-term mental health problems as well. The costs can be high -- medical expenses are 2.5 times higher and physician visits twice as high for victimized women versus non-victimized women. *Emergency room protocols to identify victims have been initiated in some hospitals but, should be made available nationwide.* Police arrest programs have demonstrated that *early intervention may be effective in breaking the cycle of violence.* However, *routine domestic violence screening by health professionals -- recently endorsed by the AMA -- is still uncommon.*

**Dental Check.** Women are 20 times more likely than men to experience temporomandibular joint dysfunction (TMJ). Pregnant women show a significant increase in gingivitis and tooth decay. Post-menopausal women are 90% of individuals with Sjogren's syndrome, an oral cavity disorder. *Failure to treat preventable tooth decay results in more than \$16 billion in annual costs.* Dental screening would identify dental problems in women at early, preventable stages.

**Vision Check.** Diabetic retinopathy is a serious complication of diabetes, leading to blindness if left unchecked. African-American women have twice the risk for diabetes as white women. Other populations, including Native American, Cuban, Mexican-American and Puerto Rican women also have a high prevalence of diabetes. Women are a larger segment of the elderly, a population also at risk for vision problems. The National Eye Institute reports that *over half the cases of blindness due to diabetic retinopathy could have been prevented if detected early.*

**Speech and Hearing Checks.** Hearing loss is the most common health problem for older women where hearing loss is associated with aging rather than physiologic dysfunction. Older women often inaccurately view hearing loss as an uncorrectable consequence of aging. *Good preventive care includes a periodic assessment for speech-language and hearing function.* Limitations in independent living and functional status due to hearing loss can be reduced if detected early.

**Prescription Drugs and Devices.** Prescription drugs and devices are an essential component of some forms of diagnosis, prevention and treatment for women. They must be included as a covered benefit for women so that primary and preventive care can be effective in slowing or halting the progression to more serious conditions women may face. *Appropriately prescribed*

drugs and devices can improve health status and lower overall health cost.

**Laboratory Tests and Immunizations.** Specific laboratory tests and immunizations are important diagnostic tools and serve to prevent illness and disease. For example, a fasting glucose test for a woman with a prior history of gestational diabetes may alert her and her provider to the onset of diabetes. Certain immunizations are known to be efficacious, such as DTP (diphtheria-tetanus-pertussis) and hepatitis B vaccine. Infectious diseases such as polio were once widespread -- there were more than 18,000 cases in 1954 -- and have now all but disappeared because of basic and low-cost immunizations within primary care.

**HIV Counseling and Anonymous Testing.** Women are the fastest growing population with HIV. An estimated 80,000 women aged 15 to 44 are currently infected. HIV seropositivity is now nearly equal among men and women in several tested populations. By 1995, the Centers for Disease Control (CDC) estimates that 75,000 women will have AIDS, compared to 26,000 today. Universal anonymous testing with pre- and post-test counseling will ensure that women will choose to be tested. Anonymous testing should be made accessible to women, in public health clinics, family planning clinics and other settings where they seek primary care services. Studies by the CDC have shown that persons who are tested at anonymous test sites are more likely to seek additional care.

#### **Primary and Preventive Reproductive Health Care**

Reproductive health services are an inseparable part of primary and preventive services for women. The full complement of reproductive services are linked to one another and are an integral part of women's health and well being. Reproductive health services must be treated as a total package of services for women. Reproductive health is part of the continuum of services over the life course because women's reproductive health needs precede, include and follow the childbearing years.

**Periodic Gynecological History and Exam, Including Pelvic Exam, Pap Smear and Clinical Breast Exam.** The gynecological history and exam includes a survey of the woman's reproductive history, current sexual activity and contraceptive use. The pelvic exam includes a check for abnormalities of the uterus, ovaries, rectum and abdominal organs. Screening for and counseling about sexually transmitted diseases is included. The Pap smear detects cancer in early stages -- cancerous cells can be detected up to 10 years before invasive cervical cancer develops. The survival rate of women with cervical cancer detected by Pap smear approaches 100%. The clinical breast exam is performed to screen for breast cancer, the second most common cause of cancer in women. The exam is also an opportunity for the practitioner to teach breast self-exam (BSE) and to make a referral for mammography. Regular, periodic gynecological history and exam is essential primary care for women.

**Mammogram.** More than 180,000 women were diagnosed with breast cancer in 1992 and 46,000 women died from the disease. Reducing the mortality from breast cancer depends, in part, upon early detection. Mammograms are a proven screening tool for detecting breast cancer in women. Research indicates that universal access to screening mammography would reduce breast cancer mortality by 30 percent. However, many sub-populations of women including older, African-American, Hispanic and poor women do not get screening mammograms. Physicians failing to recommend mammograms for their patients and the lack of both public and private insurance coverage contribute to the underutilization of mammograms.

**Maternity Care.** The full range of maternity care services,

including prenatal, intrapartum and postnatal care, are known to produce better outcomes for both mother and child. Women who lack access to prenatal care are twice as likely to give birth to low-birth-weight or premature babies. *An Institute of Medicine study reported that for every dollar spent on prenatal care to low income women, savings of \$3.38 in medical care for their low-birth-weight infants could be achieved.* Forty percent of women experience no complications during the prenatal or intrapartum period. However, the remaining 60% experience complications, about half being major complications. Maternal mortality and morbidity including infection, hemorrhage, toxemia and surgical interventions are reduced with appropriate and timely maternity care.

**Family Planning.** Family planning services reduce the incidence of unplanned pregnancies -- half of all pregnancies each year -- by increasing access to contraceptive services. Family planning also improves pregnancy outcomes for both mother and child by increasing the spacing between births. The National Commission on Infant Mortality estimates that 10 percent of all infant deaths would be prevented if all pregnancies were planned. *Every public dollar spent to provide contraceptive services saves an average of \$4.40 that would otherwise be spent providing medical care, welfare and social services to pregnant women.*

**Abortion.** Maternal mortality in New York State fell by 26% after abortion was legalized in the state in 1970. *The availability of safe abortion services is associated with declines in maternal mortality, low-birth-weight infants and neonatal mortality.* According to the Alan Guttmacher Institute, the availability of legal abortion was the single most important factor in the decrease in neonatal mortality between 1964 and 1977.

**Infertility.** Infertility affects 2.3 million couples or 1 in 12 couples in the U.S. *The National Center for Health Statistics reported that 1.3 million women had one or more visits for infertility treatment in 1988.* Diagnosis of infertility in women includes determining when and if ovulation occurs, the post-coital test, endometrial biopsy and laparoscopy. *The majority of infertile couples require conventional treatments, with fewer than 2% of couples using assisted reproductive technologies.* Infertility exacts an emotional toll on women, compounding the health consequences of this condition. The American Psychological Association has reported that infertility is a major risk factor for depression in women.

**Sexually Transmitted Diseases.** The major sexually transmitted diseases (STDs) include gonorrhea, syphilis, genital herpes, chlamydia, human papillomavirus and AIDS. *Many of the sexually transmitted diseases have no clear symptoms to alert women to seek treatment -- screening is vital.* Untreated STDs can lead to pelvic inflammatory disease (PID), a serious condition which can result in ectopic pregnancy and infertility. The Centers for Disease Control (CDC) report that at least 7 forms of malignancy have been associated with STDs. Untreated STDs can cause fetal and infant morbidity and death. *One study in California estimated that \$6 million in treatment costs could be saved in one year if patients in family planning clinics with asymptomatic chlamydial infections were screened.* A CDC pilot chlamydia screening program led to a 51% decrease in the chlamydia rate among family planning clients between 1988 and 1991.

**Menopause.** A majority of American women spend up to one-third of their lives post-menopausally. While menopause is a natural physiologic process, and not a medical condition, little is known about it. Some of the health difficulties associated with menopause include hot flashes, vaginal and urinary tract changes, thinning of bone and changes in mental health. *Health providers and educators can aid the majority of women to experience menopause without medical interventions.*



## Long Term Care

*Long term care integrates a continuum of home, community and institutional services. These services include medical services, health care, mental health services, personal care, nutrition services and social services. These services are delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity.*

Long term care is a woman's issue and a family issue. Long term care is an intergenerational issue:

- 62% of women over age 85 either reside in nursing homes or need assistance to live at home
- 40% of all Americans who need long term care services are under age 65
- a majority of Americans have experienced a long term care crisis or expect to within five years
- almost 80% of long term care is provided by unpaid caregivers, usually women family members

Surveys show that Americans are willing to provide long term care for family members but, they lack support services to help them sustain their caregiving responsibilities. *Many long term care support services can be provided in the community and in the home, including:*

- for **mental health care** the older population needs to be better served by community mental health centers, private practitioners and nursing homes than currently
- **nutritional services**, including meals, counseling and education, can be provided in congregate settings and through home-delivered meals programs
- **home care services, equipment and supplies**, including home health aid, hospice benefit, mental health care, speech, physical and occupational therapy can be offered in the home
- **social support services**, including respite care, social worker, homemaker, help with heavy chores, caregiver support and training programs enable families to provide long term care
- **community support services**, including transportation, escort, adult day care, senior centers and information and referral services
- for **prescription drugs and devices** older Americans make up 12% of the population but, purchase 25% of all prescriptions written annually, paying 64% of their prescription drug costs out of pocket
- **counseling services**, including counseling for diet, exercise, injury prevention, tobacco use, drug and substance use, dental care, violence prevention, vision, speech and hearing care

## Health Care Delivered In A Variety of Settings.

*Although most Americans think of health settings as the doctor's office and the hospital, a wide variety of settings already exist for the delivery of health care. Community health, rural health and migrant health centers, public health and family planning clinics, school-based or -linked clinics and allied health practitioners offices are existing settings where a range of health services are provided. Health care reform offers an opportunity to increase and support the cost-effective delivery of affordable services in these many settings.*

*Health care reform also offers an opportunity to restructure consumer access to health services. Primary, preventive and long term health care can be delivered in convenient, community-based and affordable settings such as the workplace, schools, day care centers and in the home. In a restructured health care setting the hospital would no longer expend costly resources to provide primary or chronic care but, would provide only acute care services. Community-based care means primary, preventive and long term care would be more accessible and less costly than it is today.*

An example of a community-based setting is a family health center, located near or at a public school and meeting the health needs of families, including women's health care needs. Community-centered care emphasizes family and individual health, convenient access and utilization of existing community resources such as schools or worksites.

#### **Health Care Delivered by a Range of Providers.**

*With health care reform, women should have the option of care from the health care provider of their choice, including the choice of women providers. Providers should include not only physicians, but nurse practitioners, clinical nurse specialists, certified nurse midwives, lay midwives, licensed clinical social workers, optometrists, podiatrists, psychologists and other allied health practitioners.*

In our current system many barriers prevent many non-physician providers from being full participants in the health care system. The major obstacle to their participation is the practitioner limits set by Medicare, Medicaid and other federal and state laws. *With a restructuring of the health care system we can enable a range of providers to provide health services in an efficient, affordable and coordinated manner.*

Midwives are an example of accessible, appropriate and cost-effective providers of primary and preventive care for women. Midwives work in a range of settings in the community -- hospitals, free-standing clinics, physicians offices, birthing centers and the home. Midwives offer maternity care services with a minimum of costly interventions. Yet, studies of midwifery care demonstrate that mortality rates are equivalent to those of physicians, certain types of morbidity are much lower, surgical procedures are fewer and breastfeeding rates are higher.

#### **Conclusion**

Health care reform is an opportunity to simultaneously provide health care to the 37 million uninsured and to create a system which offers accessible, appropriate and affordable health care for all our citizens. *It is a unique opportunity to redress many of the inequities women have faced securing health care for themselves and their families.*

This model benefits package for women demonstrates that the majority of health care for women does not demand complex technology or sophisticated medical settings -- both at a high cost. *Rather, the majority of health care for women is basic care which can be provided in low-cost settings by a range of efficient providers.*

Chairman STARK. Thank you very much.  
Mr. Griss.

**STATEMENT OF ROBERT GRISS, COCHAIR, HEALTH TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES AND SENIOR HEALTH POLICY RESEARCHER, UNITED CEREBRAL PALSY ASSOCIATION, INC.**

Mr. GRISS. My name is Bob Griss, and I am the senior health policy researcher for the United Cerebral Palsy Association. I am here testifying on behalf of the Consortium for Citizens With Disabilities. This is a working coalition of over 100 national consumer, service provider, and professional associations which advocate on behalf of persons with disabilities and their families.

People with disabilities or chronic illness provide a litmus test for the kind of health care benefit package that we are trying to develop. Americans expect our health care system to provide the health care services which we need when we need them, because we cannot always predict what our health care needs are going to be from day to day or from year to year.

I happen to have an immune deficiency which I got in response to a viral infection, and it knocked out my capacity to produce certain immunoglobulins and it requires me to get gamaglobulin infusions every month. This happens to cost about \$1,000 a month, an expense that I had not anticipated.

There are lots of disabilities that occur unexpectedly—sometimes at birth, sometimes in response to disease or accidents or aging. Interestingly enough, the average person has six to eight genes that predispose them to diseases at some time in their lives, even though they are perfectly healthy today.

What I am saying is health is an important basic need that everyone has, and that is why we need a health care system that will respond to these needs as they occur. All necessary, medically necessary services must be part of the basic benefit package.

If you need a liver transplant, then that is basic health care for you. If you don't need a liver transplant, then it is wasteful to provide it, whether you pay for it through private insurance or Medicaid or even out of pocket.

It was reported that the White House is looking at an HMO benefit package for a managed competition approach, and people with disabilities want you to know that capitation has a tendency to force very arbitrary limits on covered services in HMOs. The HMO benefit package looks comprehensive, but when you look at the specific services that people with disabilities are likely to need, you can see some very arbitrary restrictions.

Rehabilitation, for example, is likely to be a covered service, but it is often provided only if the HMO thinks that you can make substantial progress within a 60-day period. This may work for a hip fracture with no complications, but will not do you very well for a spinal cord injury or a traumatic brain injury or cerebral palsy, for example.

Durable medical equipment is also a standard benefit in HMOs, but some HMOs have a limit, like the first \$500 a year only. That may do fine for renting a wheelchair for a couple of months for a broken leg, but, frankly, a power wheelchair costs \$5,000 to



\$10,000, and for people without control over their arms and legs, that is what they need to get around.

Prescription drugs are frequently a benefit, although not required, I understand, in HMOs. But what does that actually entitle you to? Some HMOs use formularies where only certain low-priced drugs are available to you, and what your doctor thinks you need may not be provided. Some HMOs use generic substitution, without the informed consent of the prescribing physician or the consumer. For some people with epilepsy, for example, even though they are given a generic equivalent, their bodies can react very differently, creating a serious threat to their health. I am really trying to say is that we have been talking about prevention. That has gotten a lot of legitimacy in the health care debate. And we have heard from many of our panelists about immunizations for children as being a very important preventive benefit, and certainly prenatal care for pregnant women is a very important benefit, and cancer screenings for older Americans.

What I want to emphasize is that for people with disabilities, prevention of secondary complications is a preventive benefit. That means rehabilitation therapies. That means durable medical equipment and other forms of assistive technology. That means mental health services and prescription drugs and a lot of the other things that have been mentioned.

When they are not provided, we are forcing people to have medical complications which are avoidable, and we think that this is something that Congress ought to take seriously in our health care reform debate.

Instead of viewing prevention services as an add-on to costs which we are often told our country cannot afford, we have an opportunity through rehabilitation prevention and chronic care management to reduce overall health care costs. It is very ironic that in this country, which spends more per capita on health care than any other country, 40 percent more than Canada, as you know, that we are here trying to invent a basic benefit package, when other countries with national health insurance provide comprehensive benefits to everybody.

I think the American public really is going to want comprehensive benefits, and we have to figure out how to provide it. Limiting the benefits package is not how you achieve cost containment. There is a place for rationing—rationing excess capacity, rationing administrative waste, rationing excess profits. But with withholding medically necessary services from people who could benefit from them is not an acceptable way of running a health care system.

Cost containment depends on the appropriate use of medically necessary procedures, not excluding certain procedures because they are too expensive. Winston Churchill is often credited with having said “you can always count on the Americans to do the right thing, but only after they have exhausted every other possibility.” [Laughter.]

Medicare catastrophic provoked a backlash which you know, because it raised costs, but neglected to deal with long-term care, which is a major concern of older persons and persons with disabilities. The play-or-pay approach defined a basic benefits package

that left out prescription drugs and rehabilitation and durable medical equipment, to reduce the financial burden on small employers. But the American public will not be satisfied with a benefits package that is affordable to marginal employers.

If managed competition is going to offer a basic benefit package that leaves out rehabilitation and assistive technology and long-term support services, an important opportunity will have been missed to reorient the health care system from an overemphasis on high-tech acute care to prevention, rehabilitation and chronic care management.

If all people do not have access to the same comprehensive benefit package, which we believe should include all medically necessary services, we will replicate a two-tier system, increase administrative costs—as insurers try to keep track of all of the benefits that we may or may not be eligible for—and remove an important incentive to insure that the benefit package is adequate now and remains adequate in the future.

Thank you.

[The prepared statements follow:]

## TESTIMONY OF

## THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

The Consortium for Citizens with Disabilities (CCD) Health Task Force is a working coalition of over 60 national consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families.

CCD believes that comprehensive reform of our health care system requires both a new financing mechanism to ensure health care for all Americans, and a standardized comprehensive benefits package that will meet the health care needs of all Americans. We do not support an approach that would provide a "basic" benefits package for all Americans and a "supplemental" package for those who can afford to pay more. Basic health care should be defined as the care that each person needs to preserve and maintain health, not the care that an insurer—public or private—has decided it will pay for. If a person needs a liver transplant to live, it is basic care for that person. If it is not needed, or contraindicated for a variety of reasons, it is inappropriate and wasteful whether it is paid for by private insurance, public insurance or out-of-pocket.

People with disabilities, chronic health conditions, and others with specialized health care needs are very vulnerable in the current health care market. The inclusion of benefits to meet their needs is an important litmus test for evaluating the adequacy of various health care reform proposals. There are over 43 million Americans with disabilities and an even larger number of persons with chronic illnesses who depend on essential health-related services to prevent death, maintain health, and to improve and maintain functional abilities.

#### Criteria for Inclusion of Benefits in a Standard Benefit Package

We believe that any treatment which is effective and which is "medically necessary" and appropriate, should be included in a standard benefits package. The decision regarding what is "medically necessary" and appropriate should be made by the physician in consultation with his or her patient. However, the standard of "medical necessity" as currently interpreted by many private and public insurers is inappropriately focused primarily on acute care needs, and must be re-defined to incorporate a broader concept of health than merely the absence of an acute condition requiring immediate attention.

In the past decades, the incidence and prevalence of chronic illnesses and disabling conditions, illnesses and injuries have increased markedly. The definition of health care must therefore encompass the full range of services needed to treat these conditions and to increase and maintain functional abilities to the greatest extent possible. The criteria for determining whether a service is "medically necessary", must include a consideration, not only of its ability to prevent death and restore health, but also its ability to prevent illness, maintain health, and increase and maintain physical and mental functioning. Persons with disabilities and chronic illnesses are often at higher risk for developing secondary complications which can be



very costly to treat. Functional declines can also lead to expensive medical complications. Therefore, the definition of "medical necessity" must incorporate a comprehensive view of the patient's health care needs over the long-term.

### Comprehensive Benefits are Essential

CCD has developed a set of principles which we use to evaluate all health care reform proposals. The principle of comprehensiveness requires that every American have access to a health care system that ensures a comprehensive array of health, rehabilitation, personal and support services across all service categories and sites of service delivery.

There is a wide range of health care needs—preventive, acute, rehabilitative and long-term—and a reformed health care system must address the full continuum of these needs. CCD believes that a health care system designed to provide comprehensive services to persons with disabilities and specialized health needs, will, by definition, meet the needs of all Americans. CCD is especially committed to assuring that health care reform address not only the interrelated issues of financing and cost containment but that it also address the current bias in our health care system which gives greater importance to the acute care system than to long-term care, services and supports. For this reason, we have included the full range of acute, transitional and long-term services needed by persons with disabilities and special health care needs in our recommendations for a comprehensive benefits package. Whether long-term care, services and supports are financed through the acute or long-term systems or both, it is our position that they must be provided if the needs of persons with disabilities are to be adequately met.

A standard benefits package should include:

- Preventive and diagnostic services, health promotion and education services
- Inpatient and outpatient physician services
- Inpatient and outpatient hospital care
- Hospice care
- Mental health, counseling, and substance abuse services
- Prescription drugs, including off-label uses, biological, and medical foods
- Standard optical and preventive dental care
- Rehabilitation services, including audiology, vision, occupational, physical, respiratory, cognitive, psycho-social and behavioral therapies, speech-language pathology services, and therapeutic recreation
- Durable medical equipment and other assistive devices
- Short- and long-term care in nursing and medical facilities
- Short- and long-term home and community-based services
- Personal assistance and independent living services
- Habilitation services

### Nominal Inclusion of a Benefit vs. the Provision of a Meaningful Benefit

There is some discussion that the standard HMO benefit package would be a good one to adopt in a reformed health care system. We have several major concerns about this approach. While an HMO benefit may appear comprehensive, the capitation system of payment generates incentives to underserve certain individuals. For example, persons who have had a stroke often need rehabilitation services to improve their level of functioning and avoid institutionalization. If the HMO is not at risk for expensive nursing home coverage, they have no financial incentive to provide rehabilitation services and may restrict or deny rehabilitation services in order to contain their costs.

Currently, many HMOs include rehabilitation in their benefit package, but set arbitrary limitations on the duration and intensity of rehabilitation services. As a result, many persons with functional impairments due to illness or injury go without needed services.

For example, rehabilitation benefits are often limited to 60 days, and even this limited benefit can be denied if the HMO does not feel that a person will make substantial progress in a 60 day period. For many persons with functional impairments secondary to illness or injury, a much longer period is needed to achieve substantial gains. A man with a severe traumatic brain injury may need three months of intensive, residential-based rehabilitation, followed by 18 months of less intensive rehabilitation during his period of readjustment back to independent living in the community.

HMOs also set unrealistically low annual limits for certain benefits. An HMO may cover durable medical equipment (DME), but when a woman needs an electric wheelchair which costs \$4000 because she has a spinal cord injury that has left her without the use of her arms and legs, she discovers that the HMO DME benefit is limited to \$500 per year.

With regard to coverage for prescription drugs, most HMOs provide this benefit. However, many will limit the drugs that it will pay for to a formulary of low-cost drugs, and/or mandate the substitution of generic drugs without procedures to inform either the prescribing physician of the patient. For patients with epilepsy—who may have to try many different drugs, dosages and combination of drugs before finding the exact drug regime that will control their seizures—these approaches to cost-containment can have a negative impact on their health and functioning.

To address these concerns, we recommend that there be no arbitrary limits, annual or lifetime caps on any services that are medically necessary. There should also be specific policies and procedures to enable consumers to appeal any denial of care by an insurer.

### Addressing the Need for Cost Containment

The need to control costs is often cited as the rationale for restricting health care benefits. It is important to ask "whose costs" and "for how long"? If an insurer refuses to pay the charges for a treatment, a person will either pay out-of-pocket or will go without. In the first case, costs have only been contained for the insurance company, not for the person requiring care; in the second, treatment foregone may well result in higher costs later, as a person's condition deteriorates due to lack of treatment. Thus, the cost is not "contained", but merely shifted to another person, or to society at a later time. Medicare will pay for hospitalization and some nursing home care for persons who have had a stroke, but it will not pay for the hypertensive medications that could prevent the stroke. While lack of coverage for prescription drugs may reduce premiums in the short-term, in many instances, it will increase costs in the long-term.

It is not appropriate to contain costs by reducing medically necessary benefits. Given that an estimated 30 percent or more of all medical procedures are unnecessary or inappropriate, it makes more sense to focus on developing methods to reduce this waste. In the health care field, the best approach to cost-containment is primary and secondary prevention, which includes the provision of rehabilitation services. Cutting benefits in these areas will only increase costs in the long-term. Appropriate cost-containment must be achieved through the reallocation of existing expenditures so that they are spent in a more rational, cost-effective manner. Eliminating administrative waste and excess capacity in the health care system would be the best place to start.

We thank you for the opportunity to present our views on this important subject.



**TESTIMONY OF ROBERT GRISS,  
SENIOR HEALTH POLICY RESEARCHER,  
UNITED CEREBRAL PALSY ASSOCIATIONS, INC.**

My name is Bob Griss and I am the Senior Health Policy Researcher for the United Cerebral Palsy Associations, and a Co-chair of the Consortium for Citizens with Disabilities (CCD) Health Task Force. CCD is a working coalition of over 100 national consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families.

People with disabilities as a litmus test

People with disabilities and other chronic health conditions are very vulnerable in the health care marketplace and provide an important litmus test for the various health care reform proposals which are being proposed in response to the growing national health care crises of access, adequacy, and affordability. One of the most important issues in health care reform is the definition of the benefit package.

There are over 43 million Americans with disabilities and an even larger number of persons with chronic illnesses who depend on essential health care services to prevent death, maintain their lives, increase their functional abilities, prevent functional deterioration, and improve the quality of their lives. Eventually, every person will develop disabilities or chronic illnesses at some time in their lives.

Unpredictability of health care needs

Americans expect our health care system to provide the health care services which we need when we need them. It is important to have this promise of health security because we cannot always predict what our health care needs are going to be from day to day or from year to year. I happen to have an immune deficiency which resulted from an adverse reaction to a viral infection about ten years ago that knocked out my body's capacity to produce certain immunoglobulins. As a result, I need monthly infusions of gammaglobulin which cost approximately \$1000 per month. Without this standard medical treatment I would develop bronchitis and pneumonia and eventually develop a disability as a result of damage to my lungs. With the treatment, I can function very normally and work 16 hours a day like other workaholics in Washington, D.C.

Although my condition of hypogammaglobulinemia is rare, the average person carries six to eight genes, according to our current knowledge of genetics, which predispose them to diseases at some time in their lives, even though they may appear perfectly healthy today.

Health care as a basic need

Health care is a basic need that everyone has which is why we need a health care system that will respond to these needs as they occur. No one wants to be told that the only way to be covered is with a pre-existing condition exclusion (which denies coverage for the services which one is most likely to need), nor that a needed covered service is subject to arbitrary limits based on the needs

of the so-called "average patient". Certainly, no one wants to be told that needed health related services prescribed by our doctors are not considered "medically necessary" by our private insurance company whose incentive is to protect its profits.

Basic health care depends on what is medically necessary for the individual based on the judgment of the patient with his or her doctor. All medically necessary services must be part of the benefit package. **If you need a liver transplant, then that is basic health care for you. If you don't need a liver transplant, it is wasteful to provide it whether you pay for it through private insurance, Medicaid, or out-of-pocket!**

The criteria for medical necessity should not only be does the service prevent death, but does it increase functional capacity, prevent functional deterioration, and increase quality of life. Medicare regulations notwithstanding, it violates the concept of medical necessity to classify some equipment as "non-medical in nature". What is appropriate health care depends on the unique needs of the individual.

The full range of health related services which the Consortium for Citizens with Disabilities views as essential to a comprehensive benefit package should include:

- Preventive and diagnostic services, health promotion and education services
- Inpatient and outpatient physician services
- Inpatient and outpatient hospital care
- Hospice care
- Mental health, counseling, and substance abuse services
- Prescription drugs, including off-label uses, biologicals, and medical foods
- Standard optical and preventive dental care
- Rehabilitation services, including audiology, vision, occupational, physical, respiratory, cognitive, psycho-social and behavioral therapies, speech-language pathology services, and therapeutic recreation
- Durable medical equipment and other assistive devices
- Short- and long term home and community-based services
- Short- and long-term care in nursing and medical facilities
- Personal assistance and independent living services
- Habilitation services

#### Problems with comprehensive benefits in HMOs

It has been reported that the White House Task Force is looking at HMO benefits as a model for a standard benefit package. Many people with disabilities want you to know that **capitation has a tendency to force very arbitrary limits on covered services in an HMO. In order to contain costs HMOs often limit the duration and intensity of services based on the needs of the so-called "average patient".** While an HMO benefits package appears comprehensive, when you look at the specific services that some people with

disabilities may need, some very arbitrary limits are apparent which often discriminate against people with disabilities or chronic illness.

Rehabilitation, for example is likely to be a covered service, but many HMOs will only cover rehabilitation if they think that the patient is likely to make substantial progress within 60 days. Sixty days may be appropriate for a simple hip fracture with no complications but it is not appropriate for a traumatic brain injury or a spinal cord injury or cerebral palsy which may require on-going physical and/or occupational and/or speech/language therapies.

Durable medical equipment is also likely to be part of a standard benefits package in an HMO. But some HMOs limit coverage to \$500 per year. This may be adequate to rent a manual wheelchair for a brief period of recuperation from a broken leg, but not to purchase a \$5,000-\$10,000 power wheelchair which might be needed for the rest of one's life if he or she has a spinal cord injury which interferes with control over one's arms and legs.

Prescription drugs are another benefit which is often covered in an HMO. But an insurance company or an HMO may restrict drugs to a formulary of drugs that the HMO was able to get at a discount price, or may impose generic substitutions without the informed consent of the prescribing physician and the patient. This can be a serious threat to the health of a person with epilepsy, for example, whose body may react differently to different drugs, even though they are functional equivalents.

#### Prevention and wellness for persons with a disability

While prevention has become a new rallying cry in the health care debate, there is little recognition of what prevention and wellness means for people with disabilities and chronic illness. People with disabilities need various health related services to prevent the development of secondary disabilities or medical complications that may occur as a result of the primary disability. Preventive and wellness services for persons with disabilities or chronic illness must include: Home Health Services, Durable Medical Equipment and Assistive Technology, Prosthetic and Orthotic Devices, Rehabilitation Therapies (Occupational therapy, Physical therapy, and Speech therapy), Prescription Drugs, and Mental Health and Substance Abuse Services. **These preventive services for persons with disabilities are functionally equivalent to prenatal care for pregnant women, immunizations for young children, and cancer screening for older adults.**

Instead of viewing prevention services as "add-ons" to cost, which we are often told that our society cannot afford, they will actually reduce total health care costs by reducing preventable conditions, improve functional capacity and productivity, reduce dependency, and enhance quality of life.



### Redefine the concept of health

In order to effectively deal with the health care crisis, the concept and operational definition of health has to be expanded from the absence of disease or impairment to include the management of chronic conditions. The acute care oriented health care system has been shaped historically by the interests of providers to maximize income, employers to minimize premiums, and insurers to minimize their liability while covering people for one year at a time. Basic health care must emphasize prevention, rehabilitation, and chronic care management which have been essentially neglected by the acute care system.

In addition, although health care needs exist on a continuum, there is a tendency to view health care and long term care as different poles of the continuum. This is a false dichotomy having more to do with the way health care is currently funded than with the needs of individuals. If acute care is provided without regard to long term functional capacity, we save people from traumatic injury in automobile accidents but don't invest in their rehabilitation and return to life in the community. Or we provide organ transplants but don't pay for the prescription drugs which are needed on a daily basis to overcome the body's natural rejection of the organ transplant.

The Americans with Disabilities Act embraces goals of independence, inclusion, and empowerment for persons with disabilities. Without appropriate health care, these goals are empty promises. Health care must be viewed as an investment in people.

### Limiting benefits is not the way to achieve cost containment

Cost containment has to do with appropriate use of medically necessary procedures-- not excluding certain procedures because they are too expensive. We need a health care system that offers both aspirins and Magnetic Resonance Imaging (MRI) machines, and uses them both appropriately. There is something wrong with a system that creates financial incentives to utilize a \$2000 diagnostic test at the first sign of a headache, but there is also something wrong with a system that is only willing to provide aspirins to uninsured and underinsured persons with the same symptoms. Limiting the medically necessary services in the standard benefit package is not the way to contain costs.

We need a health care financing system that does not ration health care but rations excess capacity, administrative waste, and excess profits. These are the primary costs drivers in the health care system. It is criminal that our health care system withholds medically necessary services from persons who could benefit from them. Restricting benefits may appear to reduce premiums in the short run for a specific payer. But it actually results in cost-shifting to other payers, or the individual may not get the needed health related service. When this happens there are social costs to the individual, the employer, and society in general. Limiting

the benefits package rations health services by income and creates a market for private supplemental insurance with all the duplication and administrative waste that we see in the Medigap industry. It is ironic that in the U.S., which spends 40% more per capita than any other country on health care, our political representatives are trying to invent a "basic" benefit package, while other countries with National Health Insurance provide comprehensive benefits to everyone.

If Government becomes responsible for financing the health care system (instead of being just the largest payer as it is now), then the consequences of not providing appropriate health care services would no longer be viewed as "externalities". The allocation of health care resources would become more rationally related to the societal goals for the health care system which are to cover health related needs-- not ration health care on the basis of income or create a market for private supplemental insurance.

#### The American public is ready for comprehensive benefits

Winston Churchill is often credited with having said: "You can always count on the Americans to do the right thing, but only after they have exhausted every other possibility".

We already have the experience of Medicare which provides a standard acute care benefit for older Americans but leaves out many preventive services, prescription drugs, various types of durable medical equipment and other assistive devices, and long term care services. As a result, many Medicare beneficiaries are required to purchase private supplemental insurance, risk financial impoverishment, or go without certain medically necessary services resulting in preventable medical complications. Clearly, the Medicare Catastrophic Insurance Act provoked a backlash when it raised costs, but neglected to cover long-term care which is a major concern of older persons and persons with disabilities.

More recently, the "play or pay" approach attempted to define a basic benefits package that left out prescription drugs, rehabilitation therapies, and durable medical equipment to reduce the financial burden on small employers. But the American public is not satisfied with the benefits package that is affordable to marginal employers.

If managed competition is going to offer a basic benefits package that leaves out rehabilitation, assistive technology and long-term support services, an important opportunity will have been missed to reorient the health care system from an over-emphasis on high-tech acute care to prevention, rehabilitation, and chronic care management.

#### Conclusion

We believe that our health care system must provide access to comprehensive health care for everyone which includes all medically necessary services. If all people do not have access to the same comprehensive benefits package, we will replicate a two-tier system, increase administrative waste (as insurers try to keep track of what benefits a particular individual may or may not be eligible for), and remove an important incentive for everyone to insure that the benefits package is adequate now, and remains adequate in the future.

Chairman STARK. Thank you.

Mr. Lehrmann testified that the American Association of Retired Persons would prefer Congress maintaining the responsibility for defining and upgrading, or determining and refining, the benefit package, rather than assign the responsibility to some yet-to-be-determined board.

I want to ask each of you your position, whether you would prefer Congress or the board. Secondly, I would like each of you to respond as to whether or not you would support the idea of the people you represent being mandated or required to join a HIPC in order to receive their benefits. In other words, the proposal that is brewing is that each resident in America would have to join a cooperative, and that cooperative would be responsible for determining what packages would be available to those people in that area.

Mr. Lehrmann, how would you respond to having the members of the AARP mandated to join the cooperative? Would you be for that or against it?

Mr. LEHRMANN. Well, if it is built in——

Chairman STARK. You do not get "wells," you get a "yes" or a "no," you are either for it or against it, or you don't have to answer.

Mr. LEHRMANN. At this point, I do not have a specific answer to that question.

Chairman STARK. OK. Ms. McSteen, would you be for Congress or the board defining the benefits?

Ms. MCSTEEN. The board.

Chairman STARK. The board. And would you be for or against mandating your members to join HIPCs?

Ms. MCSTEEN. Against.

Chairman STARK. Against. Ms. Kolker, would you be for a board or Congress defining the benefits?

Ms. KOLKER. We think that there are really a couple of things that are critical, and the first is accountability, and the second, as I discussed in my testimony is the question of the benefits standard that absolutely must be established by Congress, because that standard really forms the basis of the whole package.

Chairman STARK. How about mandating membership in HIPCs?

Ms. KOLKER. Well, as my written statement details, women do not have access in the same way that men do, for example, to employer-provided coverage. They are disproportionately represented among those who receive dependents coverage. I think women would welcome the opportunity to have access to insurance which they do not now have.

Chairman STARK. So you think it would be fine to mandate that whatever insurance they get, they must go through these HIPCs?

Ms. KOLKER. I think we would like to think about that a little bit more.

Chairman STARK. Undecided.

Ms. KURIANSKY, Congress or a board?

Ms. KURLANSKY. I am going to respond in two ways to this question.

Chairman STARK. I don't have room for that on my chart. I am sorry, I only have two answers, that is all the choice you get. You are going to have to vote yes or no, Congress or a board?



Ms. KURIANSKY. The Campaign's perspective reflects what Ann just mentioned, we haven't taken a poll on those two questions, so I will answer from the Older Women's League perspective, and the Older Women's League perspective is that we want accountability, and we believe the most likely way to get that is by congressional mandate, with whatever subsequent board that is established to be one that is composed of diverse representatives of the women's community and others.

In terms of HIPCs, for the reasons Ann stated, we are very concerned about women who are employed in jobs which are not offering any kind of health insurance, being stuck in the least expensive plan. We have a general concern that women will be ghettoed in the lowest options. The Older Women's League supports a single-payer system and would not—

Chairman STARK. So you would oppose mandatory HIPCs?

Ms. KURIANSKY. And we would not support a HIPC process.

Chairman STARK. No.

Mr. Griss, Congress or a board?

Mr. GRISS. I think that neither choice is sufficient.

Chairman STARK. OK.

Mr. GRISS. The problem is we need a medical standard, we don't need a list of services. If you are asking whether I think Congress—

Chairman STARK. All I am asking is who you want to establish it. Do you want Congress or some board?

Mr. GRISS. We need Congress to pass the law that says all medically necessary services are available to everyone.

Chairman STARK. You would rather have Congress say that than a board?

Mr. GRISS. That's right.

Chairman STARK. All right. Then would you like to have all of your members be required to join a HIPC?

Mr. GRISS. We need a mechanism that assures equal access to those benefits for everybody. If HIPCs can do that, fine. If they cannot, then maybe we need a single-payer system.

Chairman STARK. Undecided. Thank you. [Laughter.]

I am going to have Mr. Cardin inquire, and then we will recess for at least a half hour. I am going to say we will reconvene at 10 minutes to 2, because I think we have four or five votes back to back.

Mr. Cardin.

Mr. CARDIN [presiding]. I was a little bit nervous. I thought you were calling on me to answer your questions. [Laughter.]

Ms. KOLKER. We would like to hear your answers.

Mr. CARDIN. I get a chance to wait until after May, when we see what the legislation looks like. You all are not so fortunate with Mr. Stark's questioning.

Most of you have mentioned long-term care as being an important part of a comprehensive health care plan for all Americans, and I agree that we would like to provide long-term care for our citizens, rather than having them spend down and qualify for Medicaid, which is an unacceptable alternative.

But looking at it realistically, it is likely that we may have to phase into a benefits package that provides for long-term care. We

may not be able to do everything we want in the first go-around as far as the benefits that are provided. So I would like to give you an opportunity, if you would like to take advantage of it. If we are forced to phasing into long-term care, do you have any recommendations as to how we should proceed in a phasein, what benefits perhaps should come first, again understanding that many of you have favored comprehensive long-term care as part of our package, but if we are required to do it in a phasein basis, how we should start.

Ms. McSteen.

Ms. MCSTEEN. Mr. Cardin, I feel that we definitely should have something in the law that says we will have long-term care, just as you have explained, that is, nursing home care, at least have a date of implementation. Home care, of course, is what our members are most concerned about, being able to have an independent and quality life as long as possible.

Of course, that does go right to the heart of home care, transportation, Meals on Wheels, all of the things that afford an individual an opportunity to participate in the community and not be dependent upon their children and their grandchildren.

Mr. CARDIN. Mr. Lehrmann.

Mr. LEHRMANN. Well, I would say that we certainly look upon home care and community-based care as an important component, and if we are going to have to sort things out as you suggested, that certainly might be a starting point. But we firmly believe that all aspects of long-term care have to be built into this package, if we are going to respond to what our members believe.

Mr. CARDIN. I appreciate that. I am wondering whether anyone has some specific suggestions as to what type of long-term care perhaps we should start with, whether we should be looking at large deductibles or some other way of being more realistic on the costs, at least initially?

Ms. KURIANSKY. Well, first of all, I think when we look at the continuum of services, I want to also agree with the priority in home and community-based care, but I think even within those areas there are some priorities, and I do want to emphasize the important role that women play as care givers, and that respite care should be a part of that initial package, as should the kind of home care services which are not going to be able to be available in the community and otherwise would segregate people into institutions.

So within the home care area, we would place specific priority on issues that enable people to bathe and to get fed and to have services like Meals on Wheels in their homes. The community services like adult day-care are very important. And I think we can draw on members of the community to help support some of those services, as well.

Within institutional care, I don't think we want to forget that entirely, initially, because of the current cost structure. We must move quickly to eliminate the problem of impoverishment as it relates to institutionalization.

Mr. CARDIN. Thank you very much.

I don't want to cut anyone else off. Is there—

Mr. GRISS. I guess I would like to just say that many of the services that people with disabilities need to increase their functional



capacity are not long-term care issues. They are often viewed that way, because of the way our health care system finances care today, but, in fact, should be part of the prevention benefits package. Whatever we cannot get in the prevention benefits package, then we will try to fold into long-term care, and certainly we think that home care and supports that enable a person to live at home deserves attention first. It is the most cost-effective way to proceed and we feel is the one that people are most concerned about.

Mr. CARDIN. Let me thank all of you for your testimony. We know this is a difficult process. We are working on health reform legislation. Of course, the administration will be coming forward with their proposal sometime around the beginning of May.

But we appreciate your participation at this hearing to help us to focus in on one of the most difficult issues that we must confront in health care reform, and that is what basic benefits will be provided to the people of this country.

That concludes this panel, but as the Chairman indicated, we will stand in recess until approximately 1:50.

Thank you.

[Whereupon, at 1:19 p.m., the subcommittee recessed, to reconvene at 1:50 p.m.]

Chairman STARK [presiding]. The subcommittee will resume.

Our next panel is comprised of Dr. James Scully, Jr., the deputy medical director, American Psychiatric Association; Mr. Bryant Welch, of the American Psychological Association; Mr. Morris Parloff, who is a life fellow of the American Group Psychotherapy Association; and James W. Howe, who is a current volunteer and past president of the National Alliance for the Mentally Ill.

Again, I apologize for the long wait, gentlemen. Your patience is appreciated. Why don't you lead off, Dr. Scully.

#### **STATEMENT OF JAMES SCULLY, JR., M.D., DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION**

Dr. SCULLY. Thank you, Mr. Chairman.

I am James Scully, Jr., M.D., a psychiatrist and deputy medical director of the American Psychiatric Association.

APA supports efforts to reform the Nation's health care system. More than any other physicians, psychiatrists know firsthand about the health insurance crisis facing the Nation. As the primary care physicians for persons with mental illness, we are confronted every day by the fact that many of our patients who are typically among the most seriously mentally ill have no health insurance at all. Even the Federal Government is guilty of discrimination by diagnosis, such as Medicare's requirement that patients pay 50 percent of the cost of outpatient mental health care.

We are often told that the Nation cannot afford to cover a full spectrum of services for the mentally ill under health reform. We suggest that you cannot afford not to cover mental illness.

I have submitted recent and well-respected data from Rice, et al., which shows that for every dollar you fail to spend up front on treatment, you will spend more than a dollar later in hidden costs.

Data from the National Institute of Mental Health shows that the direct cost of providing parity coverage for those with severe



mental illnesses would generate net savings of more than \$2 billion in reduced medical costs and other indirect costs.

More important than the potential for savings is the undeniable fact that mental illnesses are treatable, most typically through an appropriate combination of psychopharmacology and specific psychotherapy. For example, severe mental illnesses, such as schizophrenia and manic depression have treatment success rates of 60 to 80 percent.

In contrast, the success rates for two major treatments of cardiovascular disease—aneurysmectomy and angioplasty—have effectiveness ranges of 41 to 52 percent. Let me repeat that: NIMH data shows that treatment for severe mental illnesses are up to twice as effective as commonly accepted medical interventions for cardiovascular disease.

Congress, therefore, should not accept as "fact" false assertions that we cannot afford to cover mental illness in health reform, or that treatment for mental illness is not objectively measurable as effective. The opposite is true, and I would be glad to stack our effectiveness data against any other medical specialty.

The American Psychiatric Association recommendations for health reform are direct.

One, coverage of treatment for mental illness and addictive disorders should be included in any health care reform proposal, subject to the same limits applied to other medical illnesses.

Two, treatment of mental illness should be subject to the same protocols, the same reviews and the same cost controls as other illnesses. If we cannot show you that a given treatment is effective in meeting the patient's clinical needs, coverage for this treatment should be reviewed and, if appropriate, curtailed.

Three, persons with mental illness should have access to a full continuum of care in as wide a range of settings as possible, and the delivery system should make treatment decisions based on the clinical needs of the patient.

Four, we recommend as an interim measure consideration of a prioritization process for all medical service, including mental health services, based on common criteria for outcome and usefulness to patients.

Mr. Chairman, as the Nation's primary care physicians for persons with mental illness, we know that timely interventions can make an enormous difference to our patients. These treatments are clinically effective and cost effective. Providing uniform coverage for treatment of mental illness and addictive disorders could save the Nation literally billions of dollars each year.

Psychiatrists should be subject to the same reviews and outcome measures as are other medical specialties. Results will show what we have known all along: Mental illness can be treated with both clinical and cost effectiveness. The time for differential treatment of mentally ill rooted in fear and ignorance is past. We urge you take advantage of this unique opportunity to end health care discrimination against persons with mental illness.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**Statement of the American Psychiatric Association  
On:**

***Coverage of Mental Health Care in Health Care Reform***

**Presented to  
The House Ways and Means Subcommittee on Health**

**by**

**James Scully, Jr., M.D.  
Deputy Medical Director**

**Tuesday, March 30, 1993**

Mr. Chairman, I am James Scully, Jr., M.D. I am a psychiatrist, and serve as Deputy Medical Director of the American Psychiatric Association (APA), a medical specialty society representing more than 38,000 psychiatric physicians in the United States.

Let me note at the outset of my own statement that the APA is one of the many provider and consumer groups to support as a consensus statement the Mental Health Liaison Group document "Recommendations for Mental Health Services in Health Care Reform (March 5, 1993)." This paper will be discussed in detail by the witness representing the National Mental Health Association.

The efforts of the Clinton Administration, and the continuing efforts of the Congress and particularly yourself and members of the Health Subcommittee, to reform the nation's health care system pose a unique opportunity for redressing discrimination against persons with mental illness, and for ensuring -- once and for all -- that those who suffer from these illnesses have access to the care their illnesses require for effective treatment.

Sadly, discrimination against persons with mental illness is an ingrained aspect of American culture. Our acceptance of pejorative terminology for mental illnesses has two main results. First, it desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like the millions of Americans who suffer from heart disease, cancer, or diabetes. Second, by dehumanizing the victims and denigrating the illness, it facilitates discrimination in health insurance coverage for persons with mental illness.

More than any other medical doctor, psychiatrists know first hand about the health insurance crisis affecting the United States. As the "primary care" physician for persons with mental illness, we are confronted every day by the fact that many of our patients effectively have no health insurance, particularly if they suffer from "severe" mental illness.

Our insured patients face discrimination in the form of higher coinsurance or different arbitrarily established limits on inpatient or outpatient coverage duration for their mental illness than is otherwise applied to other non-psychiatric medical illnesses. Regrettably, many of our patients because of stigma refuse to use the insurance coverage they have purchased out of fear of being denied health insurance if they ever change jobs.

Even the Federal Government is guilty of "discrimination by diagnosis." More than 30 years after the enactment of the Medicare program, our nation's senior citizens and disabled Medicare beneficiaries must still pay out of their own pockets 50 cents of every dollar for outpatient care by a physician psychiatrist, clinical psychologist, or clinical social worker. This is direct and blatant discrimination by the Federal Government against persons with mental illness. APA has worked for many years to end the 50 percent Medicare outpatient mental health coinsurance requirement, and we urge you to make this a reality this year.

Yet such discrimination is in stark contrast to the scope and prevalence of these illnesses. Mental illness (including substance abuse) affects tens of millions of Americans, knows no geographic boundary, respects no income distinctions, and is unaffected by race, sex, or religion.

- Some 40 million adults in the United States suffer annually from diagnosable mental disorders, including mental illness and alcohol and drug disorders.
- 11 million Americans suffer from "severe" mental illnesses such as schizophrenia, bipolar disorder (manic depression), or major depression.
- 12 million children suffer from some form of mental disorder.
- Maternal alcohol abuse is the leading preventable cause of mental retardation in children.
- One third of the nation's homeless persons suffer from severe mental disorders.
- One-fifth to one-quarter of persons with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all persons with AIDS will develop neuropsychiatric problems.
- Mental illness is a major problem among our nation's elders. At least 50% of elderly nursing residents have a diagnosis of a mental disorder such as major depression. The suicide rate for the elderly is twice that for the general population.
- Alzheimer's disease is the fourth leading cause of death among U.S. adults, afflicting an estimated 4 million elderly Americans who, along with persons with other dementias, occupy more than 50% of the nation's nursing facility beds.
- 30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by more than 30 percent since 1950.

Discriminatory insurance coverage, and the concomitant lack of access to needed treatment, stem from a series of myths -- rooted in ignorance and fear -- about mental illness. The three most pervasive myths about mental illness and its treatment are as follows:

- **Myth Number One: "Diagnostic Criteria are Too Broad for Mental Illness."**

The fact is that mental disorders are at least as clearly definable as "physical" disorders.

According to recent data from the National Institute of Mental Health (NIMH), the full spectrum of all mental disorders affects about 22 percent of the adult population in a given year; 7 percent of the population have symptoms which last for a year or longer, and; only 9% of the population report some disability associated with mental disorders.

Using similar criteria, 50 percent of the adult population suffer from respiratory disorders, and 20 percent suffer from cardiovascular diseases.



Mental illnesses are thus clearly and objectively diagnosable, and do not occur in "disproportionate" numbers relative to the incidence of other non-psychiatric medical disease in the population as a whole.

• **Myth Number Two: "Mental Illnesses Cannot Be Effectively Treated."**

*The fact is exactly the opposite.*

The NIMH data shows that treatment of severe mental illnesses, including bipolar disorder, obsessive compulsive disorder, panic disorder, major depression, and schizophrenia, have success rates of 60 to 80 percent.

In contrast, the success rate for two major forms of cardiovascular treatment -- atherectomy and angioplasty -- have effectiveness ranges of 41 to 52 percent.

*Let me repeat that: NIMH data shows that treatment for severe mental illness is up to 100% more effective than a commonly accepted medical treatment for cardiovascular disease.*

Health planners should therefore be confident that coverage of treatment for mental illness in health care reform is not an "open ended" proposition -- treatments are defined and effective.

• **Myth Number Three: "We Cannot Afford to Cover Treatment of Mental Illness as Part of Health Care Reform."**

*Again, the fact is precisely the opposite: The nation cannot afford to exclude such treatment.*

In 1990, the nation's health care bill was approximately \$670 billion. Of that, the direct cost of treating all mental disorders was 10 percent, or \$67 billion.

Recent data from Rice, et al (attached to this statement) shows that the indirect costs of mental illness (i.e., the cost of not providing treatment in terms of lost productivity, etc.) was \$75 billion in 1990.

Thus, the total cost (direct and indirect) of mental disorders in 1990 was \$148 billion. This compares to the total costs of cardiovascular disease of \$159 billion in 1990, according to NIMH data. Health planners do not advocate exclusion of treatments for cardiovascular disease. Why then, should treatment of mental illness be considered for exclusion due to spurious concerns about total direct and indirect costs?

The APA's recommendation for health care reform -- set forth in our attached Statement of Principles -- can be stated quite simply:

• *We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness and those who treat them.*

• *Coverage of treatment for mental illness should be included as a uniform health benefit in any health care reform proposal, subject to the same scope and duration as applied to non-psychiatric medical illness.*

• *Persons with mental illness -- and their treating physicians and other health professionals -- should be subject to the same protocols, the same reviews, and the same cost controls as are required of patients with non-psychiatric medical illnesses and the physicians and other health professionals who treat them.*

• *We recommend consideration of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.*

- *Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, and home- and community-based services, as the patient's clinical needs require.*

We know that timely interventions, including the use of psychotropic medications in conjunction with appropriate psychotherapy, can make an enormous difference to persons with mental illness, enabling them to resume a full and productive life. We also know that these treatments are clinically effective and cost effective. And we know that providing coverage for treatment of mental illness would save the nation nearly \$100 billion in annual indirect costs incurred from our failure to provide access to care today. We thus believe that coverage of treatment for mental illness should be included in whatever health care reform model the Administration ultimately puts forward.

The APA asks simply that psychiatrists and their patients be treated like all other physicians and patients are treated under a reformed health care system. We should be subject to the same cost constraints and the same internal reviews as are other physicians and patients. We should be subject to the same outcomes measurements as are imposed on other medical specialties and their patients. These studies will show what we have known all along: mental illnesses are real, can be clearly diagnosed, and can be treated effectively. The time for differential treatment based on prejudice rooted in fear and ignorance is past.

In addition to determining the scope, duration, level, and type of benefits to be included in health care reform, the Administration, the Congress (and particularly the members of your Subcommittee), will also have to consider a host of related and complicated issues. Let me touch briefly on several of them.

First, and foremost will be the basic structure of the reformed health care delivery system. APA believes that the philosophical objectives of Managed Competition where it permits the continuation of a free market system, e.g., patient freedom of choice of physician, are well worth pursuing, and that a clearly defined, carefully structured Managed Competition system e.g., which requires treatment criteria or protocol to be based upon scientific evidence and not solely cost, offers considerable promise to the nation's health care consumers.

At the same time, APA is concerned about the impact of Managed Competition on those patients with special needs, particularly those suffering from severe mental illnesses who, as potential "high cost outliers" -- such as patients with similar chronic and long-term illnesses such as diabetes, cardio-vascular disease, etc. -- could be at risk under Managed Competition unless special precautions are taken, for example to ensure that academic centers of research, training and patient care excellence for such tertiary care patients are appropriately an integral part of Managed Competition.

Key questions about Managed Competition and its impact on mental illness include:

- Will the "basic benefits" package be permitted to include specified limited coverage of treatment for mental illness (including substance abuse) different from limits on physical illness?
- If coverage is subject to specific day or visit limits, will patients be protected from financial devastation by an effective catastrophic stop loss, or will there be a secondary annual dollar cap on total per capita expenditures on mental health care?
- How will Managed Competition ensure access to needed mental health or other health care in sparsely populated rural areas where there may be insufficient patients or facilities to support multiple competing health care plans?
- How will health care plans under Managed Competition interface with State-run mental health systems?
- Will global health budgets be imposed on top of Managed Competition reforms? If so, will separate global budgets be established for mental health services?

- How will Managed Competition affect the delivery of long-term support services to those who require them, such as persons with severe mental illness?

Second, the Administration and the Congress will have to consider the question of whether to impose global budgets. Global budgeting poses particular problems for the mental health community. APA opposes undefined global budgets which would "lock in place" current inequitable coverage and reimbursement for treatment of mental illness (including substance abuse). As noted, such treatment is, under most Federal and private health care programs, subject to artificial and discriminatory limits on scope and duration of coverage. Imposing global budgets on top of a health care system which already discriminates against persons with mental illness and their treating professionals would greatly exacerbate existing inequities, and would create major problems for delivery of mental health services.

APA is particularly concerned about the possibility that undefined global budgets would be appended to Managed Competition reforms of the nation's health care system, particularly if the so-called Standard or Basic Benefits package under Managed Competition reforms sets strict arbitrary limits on coverage of mental health services.

This "double hit" could severely disadvantage mental health care (and treatment for other chronic illnesses) by creating pressures on Accountable Health Plans to reduce access to or payment for mental health services in order to meet global budget targets.

Another major concern for APA is the interaction between global health budgets and the specific physician payment methodology established under national health systems reform. Current Medicare payment for mental health services is, we believe, less than adequate. If Medicare payment methodology is used as the basis for physician payment under Managed Competition, global budgets could severely exacerbate existing payment deficiencies, and further reallocate dollars between various specialties and across geographic boundaries.

How will budget targets be enforced? If enforcement methods include reductions in payments to physicians as "punishment" for exceeding budget targets, will all physicians be lumped under a single regional global budget? Will mental health services be subject to a separate budget? How will patients requiring higher than average levels of care (i.e., "high cost outliers") affect budget targets and hence provider payments?

APA urges Congress to not only carefully and fully consider the impact of global budgeting on access to needed services, and on overall quality of care provided, in addition to the potential cost savings, but also to respond appropriately to the specific impact of poorly defined global budgets on patients requiring treatment for mental illness (including substance abuse) particularly when patients are presently uniquely disadvantaged and in an already unequal position relative to treatment for non-psychiatric illness.

Third, another major issue will inevitably be determination of payment for whatever services are ultimately covered under health care reform. It is possible that use of current Medicare payment methodology may be considered as at least an interim cost containment measure during the transition to the "reformed" health care delivery system.

Use of Medicare's Resource-Based Relative Value Scale (RBRVS) payment methodology for mental health care poses serious problems for psychiatrists, and we believe for non-physician mental health care providers. Since the passage of the Omnibus Budget Reconciliation Act of 1989 and the subsequent release of the HCFA Notice of Proposed Rule Making to implement the Medicare physician fee schedule based on the RBRVS, APA has been working constantly with HCFA to redress major problems in the RBRVS as applicable to psychiatry.

To their credit, HCFA staff have tried very hard to respond to our concerns, but there are major and systemic problems which remain. Time precludes lengthy discussion in today's hearing, but APA would be glad to address these issues with members of the Subcommittee at a later date.



Let me cite one specific example. Briefly, the RBRVS for psychiatric services just does not work very well. A particularly problem is the fact that most psychiatric services are highly time dependent. As a result, psychiatrists, for example by their most used CPT 4 Code (90844), cannot respond to expected reduced payment under the Medicare Fee Schedule (MFS) by increasing volume or intensity of service -- yet this is the basic assumption applied to all physician and non-physician services covered under the Fee Schedule.

Put another way, time may be a relatively inconsequential variable for other procedures, but it is a significant constant for psychotherapy. Unlike other physicians, psychiatrists do not have a multitude of services and CPT 4 procedures to bill for during a typical psychiatric office visit (45 to 50 minutes of psychotherapy). As a result, psychiatrists can't increase intensity by adding services to the psychotherapy session, nor can psychiatrists increase volume by making reductions in the time that they see patients, thereby increasing the number of patients seen in an hour of time. Clearly psychiatrists cannot and will not compensate for their expected loss in reimbursement the way other physicians may be able to.

APA has previously argued in comments to HCFA on the 1992 MFS that the existing MFS Volume Performance Standard (MVPS) methodologies will unfairly result psychiatry having to "pay" for some of the "over utilization" attributable to physicians outside of the practice of psychiatry. This fear had indeed come to pass.

The MVPS for "cognitive" services -- which includes psychiatric services -- was "over shot" in 1991. Because the volume of cognitive services was greater than the target amount, the update that HCFA applied to the conversion factor for cognitive services for 1993 was reduced. In other words, the increase in the '93 conversion factor for cognitive services was lower than what it should have been because the previous year's volume target was exceeded.

Although psychiatry cannot effectively increase volume or intensity of services to compensate for expected losses in reimbursement, psychiatry is penalized -- through a lower conversion factor than that which would have otherwise been provided -- by the volume responses of other physicians. Clearly, this is a significant methodology failing of the MVPS and both HCFA and Congress need to establish some framework within the MFS that protects psychiatric services from the volume excesses of other "cognitive" physicians.

Extension of Medicare payment rates "for all" as an interim cost containment measure would thus, we believe, have a potentially severe impact on delivery of mental health care services and on access to care and would directly and adversely affect reimbursement to non-physician mental health care providers.

Finally, Mr. Chairman, in the interests of comity and most particularly in the interest of ensuring that our patients have access to needed treatment, APA has chosen to emphasize our common purpose with others in the mental health care community and to work for enactment of a broad array of mental health services in health care reform.

As we have said from the beginning, there is room enough and work enough for all licensed and qualified providers of mental health services. We will seek consensus and compromise at every opportunity, and we most sincerely hope to avoid the divisive debates which have too often characterized the various providers of mental health services.

We nevertheless note that some have suggested that the payment issue would be moot because non-physician providers would step in to "fill the gaps" in the system. We suggest otherwise. This assertion assumes that all mental health care providers have the same qualifications, education, training, areas of clinical expertise, and so on, when in fact they do not.

Certainly, there are many areas of overlapping expertise and service capacity, and I stress that APA absolutely supports access to a broad array of qualified and licensed mental health providers. But we caution that it does not follow that all providers are substitutable one for another with regard to appropriate patient care which should, in the end, be the objective of a rational health care system. We look forward to working with you to ensure access to a broad array of services in support of the clinical needs of the patient.

These concerns aside, Mr. Chairman, the APA is heartened by the prospect of reforms to the nation's health care system, and particularly by the prospect that the opportunity for reforming the system as a whole will provide us with an opportunity to end discrimination against persons with mental illness and those who care for them. We hope your Subcommittee and the Congress will seize the opportunity to redress the long-standing and unjustified discrimination against persons with mental illness which have been a feature of our health care system for far too long.

Thank you. I would be pleased to answer any questions.

TABLE 1: ESTIMATED ECONOMIC COSTS OF MENTAL ILLNESS, SCHIZOPHRENIA, AFFECTIVE DISORDERS, & ANXIETY DISORDERS, 1990 (in millions of dollars)

Type of Cost	Mental Illness <sup>1</sup>	Schitzo-phrenia	Affective Disorders	Anxiety Disorders
Total	\$147,847	\$32,538	\$30,373	\$46,551
Core Costs	141,887	29,292	29,073	46,184
Direct	67,000	17,296	19,215	10,748
Mental Health Organizations	19,516	6,520	4,873	1,985
Short-Stay Hospitals	13,392	2,595	4,695	388
Office-Based Physicians	3,655	406	1,171	356
Other Professional Services	6,599	710	2,047	645
Nursing Homes	16,478	5,316	4,543	5,460
Drugs	2,191	397	406	1,167
Support Costs	5,169	1,352	1,480	747
Indirect Costs	74,887	11,996	9,858	35,436
Morbidity	63,083	10,694	2,195	34,161
Noninstitutionalized Pop.	58,988	8,837	1,556	33,105
Institutionalized Pop.	4,095	1,857	639	1,056
Mortality <sup>2</sup>	11,804	1,302	7,663	1,275
Other Related Costs	5,960	3,246	1,300	367
Direct	2,292	599	656	229
Crime	1,777	464	508	178
Social Welfare Admin.	515	135	148	51
Indirect	3,668	2,647	644	138
Incarceration	573	150	164	58
Family Caregiving	3,095	2,497	480	80

Note: 1990 costs are based on socioeconomic indexes applied to 1985 cost estimates.

<sup>1</sup> Includes the costs of schizophrenia, affective disorders, anxiety disorders, and other mental illnesses.

<sup>2</sup> Discounted at 6 percent.

Source: Dorothy P. Rice, Institute for Health & Aging, University of California, San Francisco.



TABLE 2: DISTRIBUTION OF MENTAL ILLNESS COSTS BY DISORDER, 1990

Type of Cost	Mental Illness	Percent of Total Mental Illness		
		Schitzo- phrenia	Affective Disorders	Anxiety Disorders
Total	100.0%	22.0%	20.5%	31.5%
Core Costs	100.00	28.2	20.5	32.5
Direct	100.0	25.8	28.7	16.0
Mental Health Organizations	100.0	33.4	25.0	10.2
Short-Stay Hospitals	100.0	19.4	35.1	2.9
Office-Based Physicians	100.0	11.1	32.0	9.7
Other Professional Services	100.0	10.8	31.0	9.8
Nursing Homes	100.0	32.3	27.6	33.1
Drugs	100.0	18.1	18.5	53.3
Support Costs	100.0	26.2	28.6	14.5
Indirect Costs	100.0	16.0	13.2	47.3
Morbidity	100.0	17.0	3.5	54.2
Noninstitutionalized Pop.	100.0	15.0	2.6	56.1
Institutionalized Pop.	100.0	45.3	15.6	25.8
Mortality <sup>1</sup>	100.0	11.0	64.9	10.8
Other Related Costs	100.0	54.5	21.8	6.2
Direct	100.0	26.1	28.6	10.0
Crime	100.0	26.1	28.6	10.0
Social Welfare Admin.	100.0	26.2	28.7	10.0
Indirect	100.0	72.2	17.6	3.8
Incarceration	100.0	26.2	28.6	10.1
Family Caregiving	100.0	80.7	15.5	2.6

Note: Based on data from Table 1.

<sup>1</sup> Discounted at 6 percent.

Source: Dorothy P. Rice, Institute for Health & Aging, University of California, San Francisco.

### Key Facts

Here are *key facts about mental illnesses* obtained from the National Institute of Mental Health.<sup>1</sup> Although some of these data are limited to five major mental illnesses affecting adults, they *dramatically document the efficacy of psychiatric treatment* compared with treatments for other medical illnesses, and may be used in support of the American Psychiatric Association's principles for national health care reform. The NIMH is developing similar data for other mental illnesses, including disorders affecting children and adolescents.

#### EXTENT AND SEVERITY OF THE PROBLEM

Mental disorders are as definable as are "physical" disorders.

Using well established, formal diagnostic criteria for major mental disorders (*DSM-III-R*), mental health clinicians agree on a given diagnosis approximately 80 percent of the time.

This figure compares favorably with expert "inter-rater" agreement on clinical diagnoses in other areas of medicine.

The full spectrum of mental disorders affects 22 percent of the adult population in a given year. This figure refers to all mental disorders and is comparable to rates for "physical disorders" when similarly broadly defined, e.g., respiratory disorders affect 50 percent of adults, and cardiovascular diseases, 20 percent.

Of greater relevance to health care planning are the following data:

Less than 7 percent of the population have symptoms for a full year or longer.

Only 9 percent report some disability associated with the mental disorder.

In a given year, 10.9 percent of the population seek some mental health treatment; half of them meet criteria for a mental disorder.

Where people seek and obtain care for mental disorders:

43 percent: General health care sector

40 percent: Mental health specialty care sector

28 percent: Voluntary health sector

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<sup>1</sup> Data presented here were extracted by NIMH from a report prepared by the Advisory Council to the National Institute of Mental Health on the cost and treatment of severe mental illness.

Key Facts Attachment  
APA/Principles/National Health Care Reform

Severe mental disorders, i.e., schizophrenia, manic depressive illness and severe forms of depression, panic disorder, and obsessive compulsive disorder:

Affect 2.8 percent of the adult population -- approximately 5 million people.

Account for 25 percent of all Federal disability payments (SSI and SSDI).

### TREATMENT EFFICACY

How *effective* are treatments for severe mental disorders as compared to other treatments in medicine?

Disorder	Treatment Success Rate
Panic	80 percent
Bipolar	80 percent
Major depression	65 percent
Schizophrenia	60 percent
Obsessive compulsive	60 percent
Cardiovascular treatments	
Atherectomy	52 percent
Angioplasty	41 percent

A high proportion of treatments for severe mental disorders (including all of the above) have been proven efficacious through controlled clinical studies.

In many areas of general medicine and (especially) surgery, there is less controlled data regarding efficacy.

Selected examples of treatment efficacy and cost considerations:

#### *Manic Depressive Illness*

Without modern treatments, patients typically spent one-fourth of their adult life in the hospital and fully one-half of their life disabled.



Key Facts Attachment  
APA/Principles/National Health Care Reform

Effective preventative medications (lithium and anticonvulsants for lithium-resistant patients), often used in combination with supportive psychotherapy, allow 75 percent to 80 percent of manic-depressive patients to lead essentially normal lives.

Lithium has saved the U.S. economy more than \$40 billion since 1970: \$13 billion in direct treatment costs and \$27 billion in indirect costs.

*Major Depressive Disorder*

Treated successfully by antidepressant medications in 65 percent of cases.

"Success" rate of treatment increases to 85 percent when alternative or adjunctive medications are used or psychotherapy is combined with medications.

Psychotherapy alone helps some depressed patients, especially those with mild to moderate symptoms.

Major depression accounts for more bed days — people out of work and in bed -- than any other "physical" disorder save for cardiovascular disorders; more costly to the economy than chronic respiratory illness, diabetes, arthritis, or hypertension.

Major depression is among the most common of all clinical problems encountered by primary care physicians.

*Panic Disorder*

Effective treatment options, including classic antidepressant and high potency anti-anxiety agents and refinements in behavioral therapies, make possible treatment response rates of 70 to 90 percent.

Somatic symptoms of panic disorder often confound diagnosis leading to unnecessary expenditures of health care resources, e.g., unnecessary angiograms performed because of panic disorder symptoms of racing heartbeat, difficulty in breathing, chest pains, and dizziness, waste more than \$32 million each year.

Key Facts Attachment  
APA/Principles/National Health Care Reform

### COST OF MENTAL DISORDERS

In 1990, the Nation's health care bill was \$670 billion; direct cost of treating all mental disorders was 10 percent, or \$67 billion.

\$148 billion: total costs (treatment plus indirect costs) of *mental disorders* in 1990.

\$159 billion: total costs of all *cardiovascular system* diseases in 1990.

Severe mental disorders: Total direct treatment costs are \$20 billion per year plus \$7 billion for long-term nursing home care.

Indirect and related costs bring the total for severe mental disorders to \$74 billion per year.

### REIMBURSEMENT

Under insurance plans offering full, comprehensive, and equitable coverage for mental disorders, the percent of cost represented by these disorders plateaus at about ten to eleven percent.

Inpatient care for treatment of severe psychiatric disorders has grown less rapidly than inpatient care for all health conditions.

Under health care reform, making mental health coverage for the severely mentally ill commensurate to other health care coverage would:

Add only \$6.5 billion in new mental health care costs -- 10 percent more than is currently spent.

Produce a 10 percent decrease in the cost and use of general medical services by people with severe mental disorders.

Yield a \$2.2 billion net saving for the Nation.

Comparable data for the broadest definition of mental disorder are now being analyzed.

## THE AMERICAN PSYCHIATRIC ASSOCIATION

### RECOMMENDS THE PURSUIT OF THE FOLLOWING PRINCIPLES AS PART OF NATIONAL HEALTH CARE REFORM

The American Psychiatric Association views national reform of the health care system as an opportunity to correct historic inequities in access to health care, particularly for the mentally ill. Transition to the new system must accommodate the needs of identified vulnerable populations, especially the third of the 37 million uninsured under the age of 18, the working poor, the mentally ill homeless, and minorities. The reform must provide quality of care, medically necessary, appropriate, and cost-effective treatment of mental disorders, and prevent harm to patients.

The following principles shall apply to national health care reform:

- 1) We shall first advocate for nondiscriminatory coverage of all medical disorders including mental illness (which includes substance abuse) for any medically necessary treatment under health care reform legislation. Uniform benefits in all fifty states for the treatment of mental illness should assure universal coverage and should be equal to other medical illnesses with respect to dollar limits (annual and lifetime), deductibles, coinsurance, and stop-loss provisions. Rather than arbitrary limits on hospital days or outpatient visits, professional standards should govern the intensity and duration of treatment.
- 2) We recommend *consideration* of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.
- 3) We shall relentlessly pursue, at state or federal levels, non-discriminatory catastrophic coverage for patients with severe mental illnesses, irrespective of the basic defined benefit.
- 4) As the professional organization responsible for the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, we urge adoption of a definition of severity that is based not only on diagnosis, but also on other criteria, including duration, danger to life (self or others), interference with functioning, and interference with emotional and mental development in children and adolescents. The definition should be applicable, on a case by case basis, to severe cases of both Axis I (including substance abuse) and Axis II mental disorders in children, adolescents, and adults, including the elderly.
- 5) Utilization management should be no more stringent for mental illness than for other medical illnesses and should incorporate safeguards against clinically unrealistic, inefficient, abusive or unethical review practices. A mechanism for impartial appeal of decisions is essential. Utilization management procedures must protect the physician-patient relationship to avoid harm to the patient. The quality of care should be carefully monitored in all payment systems, in a timely fashion.
- 6) Provision must be made for cost-effective preventive services.



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7) Provision must be made for appropriate continuing care for severe mental illness.

8) We advocate access to individualized treatment in the most clinically appropriate and cost-effective environment. Funding, therefore, should be available for treatment in the full continuum of scientifically-based psychiatric treatment modalities.

9) The APA is able to support budget targets which include fair and equitable reimbursement for the diagnosis and treatment of mental illness. We oppose the incorporation of undefined "global budget targets" as part of health care reform.

10) Insurance coverage must be uninterrupted. Pre-existing illness must not be a barrier to enrollment in health insurance coverage. Premiums shall be community-rated without reference to previous history of illness.

11) Patients must be free to select their own physicians in organized systems of care.

12) Patients shall be allowed to contract for care at their own expense outside the system.

3/20/93

Chairman STARK. Thank you.  
Mr. Welch.

**STATEMENT OF BRYANT L. WELCH, J.D., PH.D., AMERICAN  
PSYCHOLOGICAL ASSOCIATION**

Mr. WELCH. Chairman Stark, Mr. Levin, distinguished members of the committee, on behalf of the American Psychological Association, it is an honor to appear before you.

The need of our people for mental health care is widespread and largely unmet. At any point in time, an estimated 15 to 18 percent of Americans need mental health treatment. Over a lifetime, about a third of us will suffer a diagnosable mental disorder. At present, about 14 million of those are children. Most will never receive any care from a mental health professional.

Despite our enormous unmet need for mental health care, there are two structural anomalies wasting millions of dollars in the mental health system, creating what can best be characterized as a "waste and want" mental health care system.

First, we are using very expensive inpatient treatment for two large patient populations who research shows could be better treated in outpatient settings. Evidence documents that all recent increases in mental health care costs have occurred either in inpatient alcohol and drug treatment or in inpatient adolescent treatment. At the same time, research now concludes that nearly 50 percent of these patients could be treated as effectively or more effectively in outpatient settings.

If we simply look at the insurance and economic incentives, it is obvious why this occurs. First, hospital-based inpatient treatment is often covered at 100 percent insurance reimbursement, with little or no expense to the beneficiary, while cheaper outpatient care insurance benefits are extremely limited and require large and significant cost sharing from the patient.

The family's decision is whether to keep a disturbing family member at home with outpatient treatment, or, instead, to put the patient in a hospital, giving the family respite and eliminating their financial burden, as well.

Second, when the Medicare DRG system was established in 1984, it was not applied to psychiatric units. As a result, hospital investment dollars quickly shifted into psychiatric facilities, doubling the number of such facilities between 1984 and 1988. This, of course, led to much greater hospital marketing for patients. It is this dual dynamic which has created the cost problem in mental health care.

The second anomaly in the mental health system is in the outpatient sector, where increasingly we are providing a level of coverage that treats the healthiest patients and excludes the sickest from any care at all. Managed care companies and, more recently, other third-party payers have redefined traditional outpatient care to make it so brief, it often is entirely inappropriate for those in greatest need.

Limited 20-session outpatient treatments for healthy adults going through life transitions, such as divorce or death of a loved one, can be justified and are good mental hygiene. But we cannot treat a learning disabled child or an abused child in the same 20-

session limited treatment. The benefit simply does not meet the need.

Making matters still worse, most managed care companies created de facto barriers, making it difficult for patients even to get the 20 sessions. So when you heard the spokespersons for the managed care companies saying that they voluntarily add a drug benefit, we hope you will consider that one reason they may do that is because they are denying people the nonpharmacological treatments which would be the first order of preference in giving treatment. And this committee was particularly helpful 3 years ago in addressing the problem which that created for the elderly in the Medicare program.

We hope that you will decide to put an end to this "waste and want" mental health system and build a more cost-effective and more humane system. Psychologists recognize that, as a provider group in such a system, we would have a fee schedule and certain reasonable price controls. We would also willingly incur a mandate to see a certain percentage of lower fee patients whose economic circumstances do not permit them to meet their copay obligations.

We ask you to end the waste and give us the chance to end the want.

We thank you for including us in your deliberations.

[The prepared statement follows:]



**STATEMENT OF BRYANT L. WELCH, J.D., PH.D., AMERICAN  
PSYCHOLOGICAL ASSOCIATION**

Chairman Stark, Members of the Committee, good morning. I am Bryant Welch, J.D., Ph.D. and I am representing the 118,000 members of the American Psychological Association. I am a licensed attorney and a board-certified clinical psychologist. We greatly appreciate the opportunity to testify before this Committee in its vital efforts to consider benefits for inclusion in a standard health benefit package under health care reform. I will focus my comments on the mental health field in which I have practiced for the last 20 years and particularly the opportunity to reduce waste while improving access by restructuring the mental health benefit.

The need of our people for mental health care is widespread and largely unmet. At any point in time, an estimated 15-18 percent of Americans suffer from a diagnosable mental disorder. At present, about 14 million of those so afflicted are children. Over a lifetime about a third of us will suffer a diagnosable mental disorder. Most will never receive care from a mental health professional.

There are two long-standing structural anomalies wasting millions of badly needed dollars in the mental health system. First, we are needlessly using very expensive hospital-based treatment for significant patient populations who research shows could be better treated in outpatient settings. All evidence documents that the recent increases in mental health care costs have occurred only in inpatient alcohol and drug treatment and in inpatient adolescent treatment. At the same time, research now concludes that nearly 50% of these patients could be treated as effectively or more effectively in outpatient settings.

Why aren't these individuals treated in outpatient settings? The reason is based on current insurance and economic incentives. First, hospital-based treatment is covered by insurance often at 100% reimbursement with little or no expense to the beneficiary, while outpatient benefits are extremely limited and require significant cost sharing. What this poses to a family is a decision of whether to keep a disturbed family member at home with outpatient treatment or, instead, to put the patient in a hospital -- giving themselves respite, and eliminating their financial burden as well. Second, in 1984 when the Medicare PPS/DRG system was established it was not applied to psychiatric units or psychiatric hospitals. As a result, entrepreneurial hospital dollars went into psychiatric facilities, doubling the number of such facilities between 1984 and 1988. This, of course, led to much greater "provider demand" for patients.

It is this dual dynamic which has created the cost problem in mental health care. If we are to allocate resources to those most in need, we must fund patients rather than facilities and give them incentives to use appropriate, less expensive care.

To reduce excess and waste in the inpatient sector, the system must impose some copayments and other forms of patient cost-sharing to ensure greater individual responsibility for treatment cost. In addition, inappropriate use and costs can be reduced by imposing precertification for and concurrent review of all inpatient admissions by using screening entities

which are free from financial interest in the institution, aggressive inpatient case management, and changes in hospital payment methodologies to eliminate the current charge-based system.

The second anomaly in the mental health system is in the outpatient sector where increasingly, we are providing a level of coverage that treats the healthiest patients and excludes the sickest from any care at all.

How did this come about? Managed care companies and, more recently, other third-party payers have redefined traditional outpatient care to make it so brief it is entirely inappropriate for those in greatest need. Limited twenty-session treatments for healthy adults going through difficult life transitions such as divorce or death of a family member can be justified and are good mental hygiene. But we cannot treat a learning-disabled child or an abused child in 20 sessions of crisis intervention. Appropriate outpatient coverage should be ensured for people who need intensive outpatient treatment--children who are suffering from abuse or violence, women who have been raped or abused, and those suffering serious and debilitating disorders which interfere with their ability to work, maintain a stable family, or maintain their physical health.

Arbitrary limits on outpatient care defy fundamental insurance principles by providing adequate coverage to those with transient disorders, but no coverage for those persons with more serious mental health problems. In particular, hardship falls on the 14 million children in need of care who overwhelmingly rely on outpatient care.

Further complicating the problem is the fact that the managed care companies use burdensome techniques such as utilization review procedures which are not cost effective for outpatient treatments.

In summary, we believe that by controlling inappropriate inpatient utilization we can free up resources for patient-appropriate, cost-effective outpatient care which, in turn, provides appropriate less expensive treatment for many now treated in hospital settings and others with serious problems for whom the current benefit systems provide no help at all. Studies show that outpatient utilization can be effectively and economically controlled by adjusting copayments rather than restricting care to the healthiest patient.

I would like to make one final comment about the system in which the benefits are administered. As some one who has practiced in the mental health field for 20 years, I recognize the allure which the managed competition model has for policy makers with its promise to make the treatment fit the patient and thereby eliminate waste. In reality, it does not work that way -- instead, the operative dynamic working in the managed care system has been that the largest profits are made by denying care to subsets of those most in need. If a capitated system is used in which providers make profits by not giving treatment, very careful independent regulation and policing

will be required.

In closing, we recognize that health care reform is extremely complex and that reasonable people can differ on the appropriate solutions to it. We in particular, as mental health providers, call your attention to the structural anomalies in the mental health field and the need to restructure the mental health benefit, which could result in the elimination of very costly waste while improving access. We appreciate the sensitivity and compassion demonstrated by this Committee to those most affected by our ailing health system, as well as your sincere efforts to find solutions to our current health care crisis. The psychology community stands ready to cooperate with you in this important task.



Chairman STARK. Thank you.  
Mr. Parloff.

**STATEMENT OF MORRIS B. PARLOFF, PH.D., LIFE FELLOW,  
AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION**

Mr. PARLOFF. Mr. Chairman, the American Group Psychotherapy Association is a national training and standard-promoting society, representing 30 affiliate regional organizations and over 4,000 professionals, including psychiatrists, psychologists, and social workers.

We are pleased to have the opportunity to contribute to your deliberations on the inclusion of mental health in the standard health benefits legislation.

I am Dr. Morris Parloff, a clinical psychologist. In my 30-plus years at the National Institute of Mental Health, I conducted and promoted the study of a full range of psychotherapies, including group psychotherapy. At the time of my retirement, I was Chief of the Psychosocial Treatments Research Branch. I currently serve as a psychotherapy consultant to a number of organizations, including the Office of Technology Assessment.

Based on a compelling body of empirical evidence, I shall report that group psychotherapy, either alone or in combination with other clinically indicated treatment modalities, provides cost-effective treatment of a broad range of psychological problems and disorders, without sacrificing clinical effectiveness.

Before that, I wish to state that the American Group Psychotherapy Association joins its mental health colleagues in expressing the firm conviction that patients suffering from psychological problems need and should have full protection and benefits comparable to those provided to the physically afflicted.

That group psychotherapy enjoys a cost-effective advantage becomes self-evident, when one considers the following: First, it makes more efficient use of the psychotherapist's time. For example, a single group therapist is able simultaneously to treat from 6 to 10 patients; second, the average fee charged each group patient is substantially reduced; and, third, the operating cost of the sponsoring treatment center or clinic are similarly reduced.

Over the past 15 years, reviews of a large number of well-controlled studies have been published. These show that by comparing the relative efficacy of group and individual psychotherapy, when skillfully applied to comparable patient samples, show no difference.

Two findings have been remarkably consistent: Patients treated in either group or individual psychotherapy are significantly more benefited, statistically and clinically, than are comparable patients in treatment control groups.

Second, a corpus of over 280 comparisons of the relatively effectiveness of group and individual psychotherapy, short-term and long-term, in the outpatient treatment of adults and adolescents failed to reveal statistically significant differences. There is no reliable evidence of any difference in the nature, speed, scope, degree, and durability of the changes they produce.

We conclude that in terms of efficiency, cost-effectiveness and clinical potency, group therapy has much to commend it to health care legislators and to third-party payers.

Thank you.

[The prepared statement follows:]

Statement of the American Group  
Psychotherapy Association  
March 30, 1993

Mr. Chairman, the American Group Psychotherapy Association (AGPA) is a national training and standard-setting society representing thirty affiliate regional organizations and over 3700 professionals, including psychiatrists, psychologists, and social workers. We are pleased to testify before your committee in the hope of contributing usefully to your deliberations on the inclusion of mental health care in the standard health benefits legislation.

I am Dr. Morris Parloff, a clinical psychologist. In my thirty-plus years at the National Institute of Mental Health I conducted and promoted the study of a full range of psychotherapies including group therapy. At the time of my retirement I was Chief of the Psychosocial Treatments Research Branch. I currently serve as a psychotherapy consultant to a number of organizations including the Office of Technology Assessment.

I shall emphasize some of the unique advantages that group psychotherapy has in promoting the twin goals of cost containment and high quality care. I shall summarize an impressive body of recent evidence to document the thesis that group therapy alone or in conjunction with other clinically indicated treatment modalities provides cost-effective treatment, without sacrificing clinical effectiveness, in the care of a broad range of psychological problems and disorders.

Before presenting the research summary on which I base this claim, I wish to state that the AGPA joins with its colleagues in related areas of mental health in underscoring our firm conviction that patients suffering from psychological disorders need and should receive full protections and benefits comparable to those provided to the physically afflicted and disordered.

That group psychotherapy enjoys a cost-effective advantage over current individual therapies is arithmetically self-evident when one considers the following: 1. more efficient use of the time and effort of the highly trained, skilled psychotherapist, i.e., the group therapist is able to treat 6-10 patients in the same treatment session, 2. reduced average treatment costs to each patient per treatment session, and 3. reduced costs to the sponsoring treatment center in terms of lower therapist fees, reduced space required, and savings on overhead costs.

It has often been incorrectly assumed that the higher costs of individual psychotherapy are justified by the greater speed, scope, degree, and durability of the changes it produces. It has also been assumed that individual therapy is uniquely effec-



tive at producing positive personality alterations and reintegrations rather than mere alleviation of symptoms.

To test these assumptions a large number of well-controlled studies have been performed, comparing the relative efficacy of group and individual therapy when skillfully applied to comparable samples of patients. The findings over the past fifteen years have been surprising but consistent.

1. Both group and individual psychotherapy are clinically effective.
2. In the corpus of over 280 comparisons of the relative effectiveness of group and individual therapy in the treatment of outpatient adults most of the comparisons fail to reveal any statistically significant differences.
3. Where statistically significant differences were found between group and individual therapy they tended to favor group therapy.
4. Only one instance was found in which individual therapy with outpatient adults was reported to be more effective than group therapy.

A single finding favoring individual therapy in the treatment of children was also reported.

5. From the point of view of clinicians and clinic administrators there is now ample evidence to justify giving priority to the expanded use of group psychotherapy.
6. In terms of efficiency and potential cost-effectiveness group psychotherapy has much to commend it to health care legislators and to third-party payers.

Morris B. Parloff, Ph.D.

American Group Psychotherapy Association  
Survey of Research Comparing the Relative Efficacy  
of Group and Individual Therapy

Morris B. Parloff, Ph.D.

In addition to the claimed unique clinical value of group psychotherapy (Dies, 1986, Kaul & Bednar, 1986, Orlinsky & Howard, 1986), it is self-evident that group psychotherapy represents a more economic and efficient approach to psychological treatment than does the more widely practiced approach of individual therapy: e.g., reduced costs to patient, more efficient use of therapist time, reduced costs to the sponsoring clinic, etc.

Many practitioners have assumed that the extra costs of individual therapy are justified by the nature, degree, scope, and durability of the therapeutic benefits it provides. To test this assumption a number of studies have compared the efficacy of group and individual therapy when skillfully applied to comparable patients. This report summarizes the findings reported in seven reviews of pertinent literature.

The duration of treatment is generally believed to be positively related to outcome. Unfortunately, the length of treatment is often difficult to ascertain from the original report. To aid the reader to interpret and weigh the findings the surveys and studies presented here have been separated into two classes of reports: A. Duration unspecified and B. Duration specified.

#### A. Duration of group and individual therapy unspecified

1. Smith, Glass and Miller. (1980). *Benefits of Psychotherapy*. Baltimore: Johns Hopkins University Press.

##### a. Method

These authors succeeded in surveying the largest body of controlled independent psychotherapy studies undertaken to date. They were among the first to apply the statistical integrative technique known as "meta-analysis" (in contrast to the "narrative summary" or "box score" methods) to a corpus of 475 psychotherapy studies. An inspection of this sample revealed that approximately one-half of the studies involved group psychotherapy.

The meta-analysis approach permits the transformation of the results of independent studies into comparable standard units. This allows the direct comparison of the findings (effect sizes) obtained by independent studies. The investigators compared the effectiveness

(effect sizes) of different treatment modalities despite the fact that such treatments may not all have been represented in the same study. The meta-analysis procedure also permits the comparison of findings despite the fact that the outcome measures used may vary across studies being compared.

The meta-analysis technique also has the advantage of independent replicability of findings and serves to minimize the influence of possible experimenter or reviewer biases found particularly in earlier narrative or clinical summaries of findings.

#### b. Findings

- 1) Psychotherapy was found to be significantly effective independent of the particular form tested.

"Individuals who received therapy were better off at the end of treatment than 80-85% of the patients who were eligible for but had not received such treatment."

According to the meta-analysis procedure the size of the treatment effects was not only statistically greater than those of the control group but, more important, for the first time it was demonstrated that the effects of psychotherapy were objectively "large" rather than, as had previously been believed, "small" or "modest."

- 2) No statistically significant differences were detected between the nature or degree of effectiveness of individual and group psychotherapy in the treatment of comparable patients.

2. Toseland, R.W. & Siporin, M. (1986). When to recommend group treatment: A review of the clinical and the research literature. Int. J. Group Psychother., 36, 171 - 201.

#### a. Method

This relatively small but careful survey of the experimental literature was aimed, in part, at responding to some of the concerns expressed by critics of the above Smith et al. survey, namely, that the results might be artifactual due to the use of seemingly lax criteria in the selection of its 475 outcome studies.

Toseland and Siporin initially identified a set of 74



studies that had compared the treatment effects shown by patients who had been randomly assigned to either group or individual treatment. Of this study sample only 32 were finally included in the survey as meeting the authors' rigorous criteria for research design adequacy.

#### b. Findings

- 1) In 75% of the studies reviewed (24 of the 32) the differences between the nature and degree of patient change evidenced in group or individual psychotherapy were not found to be statistically significant, i.e., the "no difference" hypothesis could not be rejected.
  - 2) In the remaining 25% of the studies (8) group psychotherapy was found to be significantly more effective than individual therapy.
  - 3) In no case was individual treatment found to be more effective than group treatment.
  - 4) In 10 of the 12 studies that compared relative "efficiency" of individual and group treatments they found that group therapy was regarded as more efficient or cost-effective. These authors conclude: "...given the increasing emphasis on cost containment and efficiency in the human services, as well as the tremendous need and the competing demands for scarce public funds, the issue of efficiency deserves more attention" (p.196).
3. Tillitski, Christopher J. (1990). Analysis of estimated effect sizes for group vs individual vs control treatments, Int. J. Group Psychother. 40, 215-22.

#### a. Method

A meta-analysis combining results from nine studies was conducted using 75 outcome measures applied to 349 subjects. The body of studies accepted included only those that contrasted group, individual and control treatments in a pretest-posttest design.

#### b. Findings

- 1) The effect sizes reported were even larger than those found by Smith et al.
- 2) Both group and individual treatment had effects

that were about twice as large as those found in the control groups.

- 3) With adult patients group and individual treatment effects were not significantly different across a wide variety of settings and theoretical orientations.
  - 4) In the treatment of adolescents group therapy tended to be more effective than individual therapy.
  - 5) For children individual psychotherapy was more effective than group therapy.
4. Orlinsky, D., & Howard, K. (1986). Process and Outcome in Psychotherapy. In Handbook of Psychotherapy and Behavior Change, ed. S.L. Garfield and A.E. Bergin. New York: Wiley.

#### a. Method

Examined 12 independent studies published during the period 1950-1982. These provide 14 comparisons of individual and group therapy.

#### b. Findings

Of the fourteen comparisons eleven found no statistically significant differences between the treatment effects of individual and group psychotherapy. In the remaining three reports individual therapy was more effective than group therapy. However, in two of the three instances the patients treated were identified as inpatient schizophrenics.

### B. Duration of group and individual therapy specified

1. Budman, S., Demby, A., Redondo, J.P., Hannan, M., Feldstein, M., Ring, J., & Springer, T., (1988). Comparative outcome in time-limited individual and group psychotherapy. Int. J. Group Psychother., 38, 63-86.

#### a. Method

In this study 98 nonpsychotic psychiatric outpatients were randomly assigned to either time-limited group therapy or time-limited individual psychotherapy. Outcome assessments were made by patients, independent observers, significant others, and therapists. Patients also rated their satisfaction with the

treatment form to which they had been assigned.

Therapy was conducted by five therapists, all highly experienced in the conduct of these brief therapies.

Treatment duration averaged 11+ sessions and ranged from 1-16 sessions; however, research findings were based only on those patients who participated in 1) a minimum of six or more sessions, 2) the pre- and post-treatment assessment, and 3) the one-year follow-up.

#### b. Findings

1) Overall, brief group and brief individual therapy were each effective and "comparably" effective. (There was a nonstatistically significant trend favoring group therapy.) Thus, from the point of view of the institution, the use of short-term group therapy had clinical and economic advantages.

2) Patients treated in brief individual therapy consistently expressed greater approval for their treatment than did comparable patients who had been treated in brief group psychotherapy. Thus, from the patients' point of view brief individual therapy was more acceptable than "brief" group treatment.

Note: of the 29 subjects who "defected" prior to their first treatment session, 26 had been assigned to group therapy while only three had been assigned to individual therapy. This suggests a pre-therapy patient-bias against group therapy.

2. de Carufel, F. L. & Piper, W.E., (1988). Group psychotherapy or individual psychotherapy: Patient characteristics as predictive factors. International Journal of Group Psychotherapy, 38, 169-188.

#### a. Method

Patients were randomly assigned to either short-term group therapy or short-term individual therapy. Another set of patients was randomly assigned to either long-term group therapy or long-term individual therapy. A total of fifty patients were included in the study.

Patients were rated prior to and after therapy on a comprehensive battery of patient characteristics (out-



come measures) selected as relevant to the therapeutic goals of psychoanalytically oriented therapy. Thus, four treatment groups were tested.

#### b. Findings

Data analyses which related patient characteristics and treatment response failed to identify any patient characteristics that served differentially to predict improvement for group therapy vs. individual therapy, i.e., improvement in one type of therapy and nonimprovement in the other. There were no significant differences among the effects of these four treatment conditions.

3. Piper, W., Debbane, E.G., Bienvenue, J.P., & Garant, J. (1984). A comparative study of four forms of psychotherapy. J. Consult. & Clin. Psychol., 4, 268-279.

#### a. Method

Based on judged suitability for analytically oriented psychotherapy (and the prospective patient's expressed willingness to accept either group or individual psychotherapy) a total of 79 patients were admitted into the study.

Patients were then randomly assigned to either short-term group therapy (STG), short-term individual therapy (STI), long-term group therapy (LTG) or long-term individual therapy (LTI).

Short-term therapy was limited to 6 months and long-term therapy lasted 24 months. The study examined therapy outcome, therapy process, and cost-effectiveness.

#### b. Findings

- 1) All 4 forms of therapy (STG, STI, LTG, & LTI) showed statistically significant amounts of patient improvement.
- 2) No statistically significant differences in effectiveness were found between long-term and short-term therapies. Similarly, no significant differences were found between group and individual therapies (although a greater effect size was found for group than individual therapy).
- 3) In contrast to the absence of significant main effects due to type of treatment or to duration of

therapy considered separately, clear evidence of interaction effects was found for "type" of therapy (group or individual) by "duration" of therapy (short-term or long term).

As derived from patient-judgment data, the best outcomes were associated with long term group therapy or short term individual therapy. Long-term individual therapy was ranked third and short-term group therapy was a distant fourth.

- 4) A follow-up study to assess the maintenance of change found that most of the subjects in both treatment conditions continued to improve during the year. Only social adjustment related to family and overall social adjustment (as rated by independent raters and significant others) tended to "decay."

### C. Summary and implications

1. Both group and individual psychotherapy are significantly more effective than there "control" treatments.
2. In the corpus of over 280 comparisons of the relative effectiveness of group and individual therapy applied to the treatment of outpatient adults most of the comparisons fail to reveal any statistically significant differences. In those few instances where significant differences were found they favored group therapy.
3. Adolescents treated in group therapy also showed reliably more benefit than did their peers in individual therapy.
4. N.B. We found only one study in which individual therapy with outpatient adults was reported more effective than group therapy (Hargreaves, W.A., Showstack, J. Flohr, R. Brady, C., and Harris, S. (1974). Treatment acceptance following intake assignment to individual therapy, group therapy or contact group. Archives of General Psychiatry, 31, 343-349.)

Similarly, one study reporting on the treatment of children found the effects of individual therapy to be significantly greater than those of group therapy.

5. Comparisons of short- and long-term group and individual therapies failed to reveal any statistically significant differences in effectiveness among these four treatment conditions.

6. From the point of view of a clinic administrator there is evidence to justify expanding the use of group psychotherapy.
7. In terms of efficiency and potential cost-benefit of group psychotherapy, group therapy appears to have the advantage. However, some caution is suggested by the Piper et al. finding that according to patients the most effective treatments were either long-term group therapy or short-term individual therapy. "Short-term group therapy was rated a distant fourth."
8. From the vantage point of patients there appears to be a bias against group psychotherapy. The finding that group therapy is relatively less acceptable to prospective and actual patients remains an important problem for clinicians to anticipate and deal with.
9. It may be necessary to improve techniques for enhancing patient acceptance and participation in group therapy. Such mechanisms may involve a) educating clinic staff members who have the responsibility of making initial matchings of patient clinical needs and appropriate treatment referrals, regarding the value of group psychotherapy, and b) devising procedures for more effectively orienting prospective patients to accept and remain in group therapy.



Chairman STARK. Thank you.  
Dr. Howe.

**STATEMENT OF JAMES W. HOWE, CURRENT VOLUNTEER AND  
PAST PRESIDENT, NATIONAL ALLIANCE FOR THE MEN-  
TALLY ILL**

Mr. HOWE. Mr. Chairman, distinguished members of the subcommittee, thank you for the opportunity to speak on health care reform.

I am James Howe, father of four children, two of whom have the diagnosis of schizophrenia. I am a former president of the National Alliance for the Mentally Ill, which is called NAMI, and still an active volunteer with that national movement.

NAMI is a self-help organization of families of persons of all ages with severe mental illnesses and of those persons themselves. We know better than anyone the emotional suffering and financial disaster that accompany these devastating brain diseases. This is particularly true of young families whose underage child becomes ill and whose insurance coverage may be used up even before that child becomes an adult.

NAMI's membership totals 140,000 persons, including voters in all congressional districts. NAMI members subscribe to the prevailing scientific view that severe mental illnesses are physical diseases of the brain, such as schizophrenia, depressive illness, manic depression and deficit hyperactivity disorder, particularly in children, among many other disorders of the brain. These are no-fault brain disorders, not moral flaws.

Although there are no cures for these brain disorders yet, these are very treatable diseases through appropriate medication, along with community-based rehabilitative services. These are episodic, but generally long-term diseases.

Therefore, there must be long-term care and treatment, and these persons require a variety of support of the kind needed by all of us, except that we can generally provide them for ourselves; whereas, in many cases, persons suffering from these brain disorders cannot.

These are such supports as income security, vocational rehabilitation, including employment and training for those who recover enough to work in low-stress jobs, and supported housing.

Now, some of these are not medical services, but they are needed, and if they are not available, then the ill person often crashes, goes back into the hospital, is too soon discharged, sent out into what to him may appear to be a hostile community, too soon relapses, too soon back into the hospital, too soon discharged and on goes the distressing cycle that we call the revolving door.

This is far too costly. The admissions phase of hospitalization is by far the most expensive, and the revolving door syndrome keeps many persons intermittently in this expensive phase. This whole system is costly in the extreme, both in money and especially in human suffering.

Mr. Chairman, if this essential community support part of the care and treatment cannot be supplied under the reform of the American health system, then the same Congress that supplies the medical part that is needed has a strong interest in insuring that

the nonmedical supports are provided through other systems, and the reformed health system should at least provide the means to link the patient with the systems that do supply nonmedical supports. Otherwise, you will have missed an important step to control costs.

In a real sense, in the case of persons with these brain diseases, the medical and nonmedical supports that I have described constitute a real prevention program. We cannot yet prevent the initial onset of the disease, but we can prevent them from these indescribably painful cycles that are often accompanied by a long-term downward course of the illness, we can stabilize the course of the disease, and we can restore many of these people to some of life's satisfactions, including becoming productive, even taxpaying citizens.

For any chronic disease such as these brain disorders, the reformed health care system should have no arbitrary and discriminatory limits on duration and scope, no dollar ceilings, either lifetime or annual, and certainly no limit on the number of visits per year. And, of course, the reform system should put no limits on prescription medications.

In some instances, their costs may seem high, but they are minuscule in comparison with the revolving door syndrome.

We should not impose such limits on these persons, any more than we should do so on the treatment of persons, let's say, with diabetes. And there should be no requirement of demonstrated improvement. Just preventing further deterioration is progress for some. And the good news is that if provided treatment and stability, many such persons make dramatic progress after years of stagnation. This is increasingly true with the development of new medications.

We believe that the benefits now provided under Medicaid and Medicare should be preserved in the new system. I have attached to my written testimony a list of minimum specific services that should be included in the reform package.

Mr. Chairman, we in NAMI believe that the reasons for the decades of discrimination against mental illness coverage in past and present systems are based on the ancient beliefs that these illnesses were moral, not medical problems. Those dark beliefs have been dispelled by the light of science. Science is moving into the 21st century in its views of mental illness, and it is time to bring our health system into that century, also.

Thank you, Mr. Chairman.

[The prepared statement follows:]

PREPARED TESTIMONY OF JAMES W. HOWE  
CURRENT VOLUNTEER  
AND  
PAST PRESIDENT  
OF THE  
NATIONAL ALLIANCE FOR THE MENTALLY ILL  
BEFORE  
THE HOUSE COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEE ON HEALTH

March 30, 1993

10:00 A.M.

Room 1310 Longworth House Office Building  
Washington, D. C. 20515

**BENEFITS FOR INCLUSION IN HEALTH CARE REFORM**

Mr. Chairman, distinguished Members of the Subcommittee, thank you for the opportunity to address you today at this hopeful and historic time for America's Health Care Systems. I am James Howe, a former President of the National Alliance for the Mentally Ill -- "NAMI" in Washington alphabet soup -- and still an active volunteer in the National office.

NAMI is a self-help organization of families of persons of all ages with severe mental illnesses and of those persons themselves. We know better than anyone the emotional suffering and financial collapse that accompany these devastating brain diseases. NAMI's membership totals over 140,000 persons nationwide, including in all of the Subcommittee Members' districts. Our organizational structure consists of a 15-member elected volunteer Board, a national office in Arlington, Virginia; 50 state offices; and nearly 1000 local affiliates.

NAMI members subscribe to the prevailing scientific judgement that severe mental illnesses are physical diseases; and they include illnesses such as schizophrenia, depressive illness, bipolar disorder, panic disorder, obsessive-compulsive disorder, autism, and attention deficit hyperactivity disorder in children. They are complex disorders with biological, neurological and possibly genetic underpinnings. They are "no-fault brain disorders" -- not the result of parenting failure or moral flaws. The federal government's Executive branch and your Congressional branch strongly agree, as expressed through the research and writings of the National Institutes of Health and the Office of Technology Assessment, and as expressed through your Congressional Resolution on the "Decade of the Brain."

Sadly, today there are no known causes or cures for these brain disorders. But, in most cases symptoms can be managed through appropriate *integrated and timely* application of medication, community-based rehabilitative services, and supportive housing. The "call of the chair" today is targeted on what we witnesses think the standard benefit package for health reform legislation ought to be.

Characteristics of covered services

NAMI thinks that in addition to covered services for all other physical illnesses, there needs to be, for persons with severe mental illness, a schedule of covered services

- \* *that are integrated both with each other and with benefits and services that are in addition to the reform package.*
- \* *which enjoy parity with other illnesses in amount, duration, and scope of financial coverage.*
- \* *for which a treatment team accepts responsibility, in acknowledgement of the cognitive and other deficiencies suffered by the consumer, but respecting the consumers right to refuse treatment.*

Public Programs offer Model

Most, if not all, of the services our loved ones require are covered now in Medicare and Medicaid -- but in spotty fashion across states, and poorly integrated with each other.



[A sobering aside on this is the fact that to become eligible for either the social insurance or means-tested government program, a consumer must first have gone through sufficient bouts with the illness to be declared disabled by Social Security's Disability Determination Service.]

### Benefits that work

Benefits that are working for persons with severe and persistent mental illnesses include services in the *acute medical*, *psychiatric rehabilitative*, and *long term* categories. Not all are delivered by traditional health professionals. (A specific list developed by the Mental Health Liaison Group is attached as an appendix.)

All of these must be provided post-reform, either in the reform package or as a subsequent initiative. In particular, what is now being supported through Medicare and Medicaid must continue without interruption.

### Controlling and reducing Costs

Reliable and humane delivery of such services offers a significant cost avoidance mechanism for both public and private sectors of U. S. society. All of the population for whom we advocate are perhaps "outliers" to actuaries and economists. But they're here and they're hurting. A decent society has to do better by them than the private insurance system has done. We truly believe that doing better will utilize resources at far more appropriate levels of care than the current situation tends to do. And this will rationalize, control, and ultimately reduce expenditures. One of the first and best long-studied models of community care for this population estimates that it has saved 2/3s of the cost of resources that its patients would have otherwise consumed.

### Arbitrary limits inappropriate to disabilities and chronic illnesses

As for any chronic illness, reliable and humane delivery means that arbitrary -- and discriminatory -- limits on amount, duration, and scope must be eliminated. Persons with severe mental illness are in some ways like persons with diabetes. A reasonable benefit schedule cannot say to them that they may only be treated so many times in a year, or so much altogether in a lifetime. The major criterion for medical necessity must not be based upon or limited to demonstrated improvement. In many instances, persons in these categories -- and their physicians -- consider the absence of further deterioration, or the slowing of the rate thereof, as positive treatment outcomes. And sometimes dramatic progress does occur, after years of stagnation.

### Need for treatment team responsibility

We family members are always decrying the "revolving door" of: too-soon discharge, no follow up in the community, too soon readmission, a far longer stay than would have otherwise been needed, too soon a discharge, and so on and so on. Just because you're weary of hearing us say it doesn't mean it isn't still going on. As states try to reconfigure their programs to get more out of the public dollar, we are hearing the evidence yet again.

The alternative is less costly -- and with far better outcomes for our loved ones. The current system for persons with severe mental illness may ineffectively waste resources by letting patients deteriorate far enough that hospital stays considerably more frequent and lengthy than they need to be become the norm. They are frequent because too often there is no good community-based support system. In far too many instances, our system that knows of the patients cognitive and other deficiencies, still fatuously expects the patient to be his/her own care coordinator, and denies responsibility when he/she is not. It is costly in the extreme, both in dollars and in human suffering.

### Non-health Services outside of Reform Construct

NAMI knows that income security, vocational rehabilitation, employment & training services, and supported housing are all needed by our loved ones. We know all of these won't and shouldn't be included in health care reform. NAMI insists that the same Congress and Administration that look at health care reform, do so in the context of these

other needs of the ill person. Relapse more frequent and more prolonged than would otherwise occur is often forestalled through stable provision of these services. The community care model I previously mentioned -- while it does not provide or fund these other supports -- does assume responsibility for reliably connecting its consumers to them.

### Prevention

If there is such a thing as prevention for those with severe and permanent brain disorders, you have just heard me describe it. There is no vaccination, no protection against initial onset. But recurrent relapse and deterioration can be largely prevented, insofar as we know how to do that within the bounds of involving the consumer in treatment.

### Prescription Drugs

One of the recent keys to such stabilization and independent living for our loved ones has been the remarkable advances that science, largely with Congressional support, has made over the past decade. Psychopharmacological agents undreamed of twenty years ago, are making recovery much more frequent. Maintaining and improving this recovery level for consumers should be an objective of reforming the health care system.

The logic of covering the treatment that works is elegant and simple. You cannot leave prescription medications, no matter what their cost, out of the coverage package if they are the only treatment mode of choice and efficacy. Mr. Chairman, we know that you would like to see Medicare cover prescription drugs. NAMI would very much like that too. Pharmacy bills of close to \$1,000/month are not uncommon for consumers who are on Social Security Disability Insurance, and thereby Medicare -- but who are not dually eligible for Medicaid.

Mr. Chairman, distinguished Members, please learn more about this especially vulnerable, underserved population and their needs. You've invested much in public resources over the decades learning what works and what doesn't. Let us access that knowledge and utilize it as we reform the system, and become the caring and humane society the President envisions when he says we cannot afford to waste a single person.

Thank you.

#### A. *THIS CONTINUUM OF SERVICES MUST BE COVERED (FINANCED) FOR PERSONS IN NEED OF ALL AGES -- CHILDREN AND ADULTS -- IN THE NEW SYSTEM:*

##### 1. *Mental health services include the following as now defined through Medicare and/or Medicaid policy:*

- a. *Assessment and diagnosis - same co-payment as any other health assessment or diagnostic services.*
- b. *Emergency services, round-the-clock:*
  - (1) *hospital emergency services;*
  - (2) *crisis residential services;*
  - (3) *crisis intervention in the home.*
- c. *Medication management services - same co-payment as for any physician visit.*
- d. *Other outpatient/ambulatory, including:*
  - (1) *Short-term psychotherapy: individual group, or family - with co-payment arrangements and utilization management.*
  - (2) *Extended psychotherapy: only for individuals with severe impairment - with prior authorization and periodic review.*

- (3) *Partial hospitalization and psychiatric rehabilitation - utilization review periodically for necessity and appropriateness.*
  - (4) *Case management services when support services from multiple agencies required.*
- e. *Acute hospital services to stabilize the patient's condition in any currently Medicaid-eligible facility, with periodic utilization management. Includes preparation/ implementation of discharge plan to ambulatory services.*
- (1) *Facility certification through Medicare and Medicaid standards.*
  - (2) *Specialized units and services required in facilities serving children and adolescents.*
  - (3) *Current exclusion of facilities run by state governments from reimbursement should be retained.*
- f. *Prescription drugs: all necessary to treat mental illness, including benzodiazepines and drugs used to treat anorexia.*

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Model benefit excerpted from MHLG's March 5, 1993 "Recommendations for Mental Health Services in Health Care Reform", 3/17/93, rab



Chairman STARK. Thank you.

You have already heard the question, and I would like to poll the panel. Would you prefer to have the benefits determined by Congress through legislation, or would you prefer, however you envision this yet-to-be-determined board being convened, to leave it to either a Federal or 50 separate State boards?

Dr. Scully.

Dr. SCULLY. Thank you, Mr. Chairman. My organization has not taken a position on that, but if I can speak for myself—

Chairman STARK. Please.

Dr. SCULLY. Having been out West for 20 years and new here in Washington, I can tell you that I think, since Congress is going to have to appropriate the money, Congress ought to decide what the benefits are, and Congress is also more responsive to the people, so I would be in favor of Congress doing that.

Secondly, in terms of HIPC, since my organization has not yet taken a position on that, but I am not sure how that is going to work, and I would expect before it is all over we are going to end up with single-payer.

Chairman STARK. I hope you are right.

Dr. Welch.

Mr. WELCH. Mr. Chairman, you do not know who is going to be on the board yet, do you? [Laughter.]

Chairman STARK. Mrs. Clinton, for one, but go from there. [Laughter.]

Mr. WELCH. Maybe with that qualification, I had better abstain. We prefer Congress to determine the benefit, and the reason is because we feel there is greater accountability.

Chairman STARK. I wish I was this popular in my own district. [Laughter.]

Dr. Parloff.

Mr. PARLOFF. Obviously, I have not had an opportunity to find out what the position is. Speaking for myself, I would prefer Congress.

Chairman STARK. I guess I did not ask you and Dr. Welch about the HIPCs, to the extent you are familiar with what they might or might not be. I would ask Dr. Welch and Dr. Parloff whether you think that your—I guess you would have to speak for your clients or patients, whether they would prefer getting their benefits by having to join or become part of some local co-op and take the plans offered to that co-op, or would they prefer the relative freedom, say, of a program like a single-payer system or an or all-payer system like Medicare? Do you have any feelings about that, Dr. Welch?

Mr. WELCH. Yes, we would certainly prefer a single-payer, but I think given the difficulty of putting a legislative package together, if you folks come up with the package that will take care or get babies immunizations and what have you, we are going to support what you come up with, but the HIPC is not our preferred model of doing it.

Chairman STARK. Do you have a personal feeling about that, Dr. Parloff?

Mr. PARLOFF. Yes, the single-payer.

Chairman STARK. Mr. Howe.

Mr. HOWE. With respect to your question about whether I would prefer a board or Congress, and I speak for myself, if I thought we could stack the board with our friends, I would prefer a board. [Laughter.]

Our track record on that is not as good. Congress has been very good to us and I would prefer the Congress. I think our Constitution really requires it. This is quintessentially a political decision. Boards do not make good political decisions, and Congress has got lots of experience in that.

Chairman STARK. It sounds so self-serving when I say it. [Laughter.]

Mr. HOWE. On the HIPC, I am afraid I have no position.

Dr. SCULLY. Mr. Chairman, I think we are all saying that the big issue for all of us is the nondiscriminatory treatment of the mentally ill in whatever system you devise.

Mr. HOWE. Amen.

Chairman STARK. I concur and you have a strong advocate in my colleague Congressman Levin, so I will let him take over.

Mr. LEVIN [presiding]. Thank you, Mr. Chairman.

You know, it is hard to judge where health reform really is today, except that it is moving and I think in the right direction.

As to mental health services, it is my guess that considerable progress has been made elevating awareness of the need to take a hard look at mental health services in redesigning our health system, and I think both Hillary Clinton and Tipper Gore have been pretty clear on that.

But let's spend just a couple minutes talking about where we go from here or where the issues goes from here, because while I think there is a greater openness to the inclusion of mental health benefits, I think the discussion is a long way from your suggestions that it be on a parity basis.

I don't know what you have submitted to the task force—probably a lot—but it would be helpful if you could take that material and do the following for them and for us, and we are really part of the same effort, I think. And that is to try as much as you can to analyze in cost terms what the tradeoffs are.

For example, Dr. Welch, you talk about the kind of waste and the wrong emphasis in the system. I think at some point there will have to be a decision that if you very much change the emphasis from inpatient to outpatient treatment, at least in many instances, what will it mean for the cost of the system? You have some figures here, but I think there is a lot of skepticism that you can change the emphasis in the delivery of mental health services, remove all of the caps that don't exist in other instances of care, and not substantially increase the cost.

There is going to have to be some sense of what the tradeoffs are, what the opportunities are, what the likely cost implications, or else I think you are going to see a tendency to do the same as we are doing in Medicare.

There has been some progress, I hope real progress, but there still is a major differential in approach, right? I mean the 50-percent copay is a huge differential. One could call it a discrimination. I really think if we are serious about elevating mental health services, we have to have a combination of idealism—it is not idealism,



I think it is realism—plus hard-headed analyses of what changes would mean and what they would cost.

Mr. WELCH. Could I respond to the comments about the costs?

Mr. LEVIN. Please.

Mr. WELCH. I take those as very constructive suggestions and we will heed them. I do want to clarify that we are not talking about taking controls off the outpatient benefit. What we are talking about is moving to a 50-percent benefit, so that you would move from a situation where, with a lot of the managed care companies now, you have 20 hours of treatment typically paid at 80 percent.

What we are saying is that if you then extend that out and use a 50-percent copay as your cost control, that you can then let the patient and the provider make that decision, and the econometric models we have that really come from some of the most conservative health benefits administrators around and from health economists, that it would only increase the costs of the mental health benefit by 4.5 percent.

Mr. LEVIN. Right.

Mr. WELCH. That is not even allowing for any savings that you would make in the inpatient area. The point we are making is that the cost of that outpatient treatment is very, very minimal. If you fix the adverse selection problem in outpatient treatments, you don't have a cost problem there.

So we feel that the reason we have started by funding hospitals is because that is the way the insurance system grew, not because we rationally planned it that way and so on. But that outpatient benefit does not cost a lot of money.

Mr. LEVIN. Do you think this approach is basically accepted throughout the mental health provider and consumer community? Do you think if in the standard benefit package there were no major limitation on visits—I am not saying none, but if basically that were eliminated for most everybody, and you had a 50-percent copay, do you think that would be universally accepted?

Mr. WELCH. Well, I don't think there is anything to be universally accepted, but I think it would be a much better system than what we have had heretofore, where all the resources that we decide we can allocate to outpatient treatment, we are spending in treatment formats that primarily take care of the people who are the healthiest members of the outpatient population.

Mr. LEVIN. Let me ask you—and we have other panels, so I will be very brief. I do not say this unsympathetically to the approach, but how do you square it, Dr. Scully, with your testimony about eliminating artificial and discriminatory limits on scope and duration of coverage? How do you square a 50-percent copay with that?

Dr. SCULLY. Well, if you think about what is the copay for, when we have somebody with heart disease, we don't say you get 20 visits because that is all we are going to limit you to. We say we will take care of your heart disease and we need to have an outcome study that says what is the required treatment for that.

We know there are differential treatments for different problems and that is what I was trying to address. Somebody who has a serious—

Mr. LEVIN. But there is no 50-percent copay for heart surgery.

Dr. SCULLY. Exactly, and that is—



Mr. LEVIN. I am not saying I am opposed to it, but how do you rationalize a 50-percent copay for outpatient mental health care?

Dr. SCULLY. I am not attempting to rationalize it. I think it is discriminatory. I think if one—am I answering your question?

Mr. LEVIN. Yes, but you two don't agree.

Mr. WELCH. Could I respond?

Mr. LEVIN. Yes.

Mr. WELCH. If you are asking me if I would rather have a 50 percent or an 80 percent, let me be clear, I would rather have an 80 percent. But when we are being told by a number of people that we cannot afford to go beyond the 20-session limit, then I am saying if we object to the 50 percent proposal, because it is not 80 percent, we are letting the perfect be the enemy of the good.

With 50 percent, you would get a lot more people in treatment, the people who would be in treatment would be highly motivated. I think you could count on the mental health community to accept a mandate to treat a lot of people who can't pay the copay, to treat them at reduced rates. I think you could do a lot with it.

So the only reason we are talking about 50 percent is the cost figures do work and it does get more care to more people.

Mr. LEVIN. Dr. Howe, you wanted to say something?

Mr. HOWE. Yes. You asked about whether we could rationalize the cost factor against bringing people out of the hospital and putting them into the community, what would that do to the cost.

There is a study out of the University of Wisconsin about 8 or 10 years old now which compared the—in Dane County, Wis., they have an exemplary community support program. Their goal was to get people out of the hospital, recognizing that it was breaking their bank, because hospitals are so expensive. These are State hospitals, particularly.

In 1988, they had 11,000 hospital-days per year, and in 1985 or so—I have forgotten precisely the date—they had dropped that to 2,000 hospital-days. Now, clearly, a hospital costs an awful lot more than a good treatment system in the community.

They also went on to do the cost studies. They found that the costs did not drop for the total of Dane County. It did drop per patient. What you did was to take all of those people who were in the streets, who were wrongly in prisons or jails, who were living in filth because they are mentally ill, and you gave them some services, so the cost to the whole of society may not go down, but it may go up. That is the decent thing to do.

Mr. LEVIN. I was not questioning that. Even though I must say some of the efforts at localizing mental health services has been an excuse to reduce expenditures, but that is a different issue.

Mr. HOWE. That is right.

Mr. LEVIN. Why don't we end this. I would like to just give you my reaction as to where this issue is at the moment. I asked you these questions because I am really supportive of your efforts to try to find some realistic steps that can be taken within reform, perhaps accepting less than every one would want. Because I think the first hurdle for mental health benefits has been jumped, kind of the mindset, with the help of Mrs. Clinton and Mrs. Gore. They are not the only ones, but they have been instrumental.

I think the next hurdle is also a large one, and that is trying to figure out a system that delivers the services better, more effectively to more people, without being so expensive that even if people like the fact that we have jumped the first hurdle, they kind of turn it off as we get to the second one. I really think that there is that hurdle for a lot of people imbedded in their psyche, as well as their ledger book.

My colleagues, I am sure, will be reviewing your testimony. I think this has been very, very helpful.

We will continue on this subject. The next panel is Stanley Jones, Michael Bowers, Robert Trachtenberg, Edward Diehl, and Rev. Woodruff.

Well, you have heard some of the discussion today, so proceed as you wish. All of your testimony in each case will be entered in the record, and to the extent you want to address what we were talking about before, do so. It is late in the day. That should not crimp your style, but I think the more you get to what you think is the gist, the better, because your full testimony will be looked at in the days and weeks ahead.

Shall we start with Mr. Jones?

**STATEMENT OF STANLEY JONES, CHAIR-ELECT, PUBLIC POLICY COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION AND PRESIDENT, MENTAL HEALTH ASSOCIATION OF GEORGIA**

Mr. JONES. Mr. Levin, I really appreciate your comments during the last panel. I know the hour is late and I know you have saved the root canals for last, so I will try to be brief.

Mr. LEVIN. Not always. Sometimes you do it at 8 in the morning. [Laughter.]

Mr. JONES. Mr. Levin, I am the chair-elect of the Public Policy Committee of the National Mental Health Association. I am a lawyer from Atlanta. I also chaired a reorganization commission for mental health services in Georgia, which has just finished its work.

I would like to address some of the things that you specifically asked in the last session. We have prepared testimony for the record, and I think the most salient aspect of it is that it includes a position paper that has been approved by 34 different mental health organizations. It is called "Recommendations for Mental Health Services in Health Care Reform." It does address the copayment questions that you were asking the previous panel about.

We vigorously support nondiscrimination against mental health benefits. On the copayment issue, what we have urged on the Congress and also on Mrs. Clinton's task force is that the same copayment or cost control measures be applied to mental health as to any other services.

We have suggested, and we believe that 34 groups now support the notion that there might be variable copayments in outpatient mental health. So you might have no copayments for entry into the system, and then you use utilization review controls. Then you raise copayments for the middle of treatment, maybe as high as 50 percent, in order to regulate use. But when it is clear to the utilization review managers that the course of the disease needs more ex-



tended care, then you go back down to a lower copayment, so that people who are seriously ill can actually get the treatment that they need and deserve.

I want to emphasize again that these recommendations for mental health services and health care reform are supported now by 34 different mental health organizations. And dealing as we do in issues and affairs of the mind, I think you might find it unusual that we have gotten this many people to agree on issues of that sort.

The second major point made in this paper is that we hope the plan will include the full range of support services that people need to get better, and that we know can successfully get people better. Not just inpatient care or outpatient care, but also psychosocial rehab, prescription drugs, assessment and diagnosis emergency services need to be covered. We hope that the mandate is set by Congress and we would like the mandate to be strong enough to allow the whole array of services to be funded in the new system.

We know that mental health care works. The most recent powerful example probably is Clozapine. People who have been chronic schizophrenics in the back wards of many of our State hospitals, at a cost of \$100,000 a year, can now get successful medication treatment, in many cases for \$5,000 a year, and survive very successfully in residential programs, outpatient services, and social rehab programs that cost dramatically less.

We have some data in our paper that show, for example, in Maryland, the cost of inpatient care for a year is \$100,000. The cost of a successful range of outpatient services with stabilization in the acute environment, when it is necessary, costs \$30,000 a year.

Another example where it is very clear that mental health treatment works, is that you can medicate depression at a cost of a couple dollars a day. For the elderly, for example, you may be saving the cost of nursing home care at a cost of \$80 to \$150 a day.

I think the burden is on us to prove to the Congress that mental health care is effective. We believe it is time now to end the discrimination against mental health care. Some of the most recent data on the prevalence of mental illnesses show that the number of people in America who suffer from them is as high as 17 percent in any one year, and 15 percent in their lifetime.

I dare say there is no other single medical illness that has this level of effect on the American population, and I think, in and of itself, that says mental health care deserves to be treated. Needless to say, national health care reform is about access to care for all Americans for the services that we need. Mental health services are there at the top. It is one of the most demanded services for the entire population.



The last point in our paper which I think is something to be thought about is that the States already make a huge contribution to mental health out of direct State dollars, not even counting what the Federal Government supplements with the Medicaid. This is a large resource to be used and integrated into the system that the Congress designs. I hope that will be remembered and taken into account, both for States' standard-setting role and their provision of inpatient care for a large number of indigent citizens.

Those are the major points in our paper, and I would be glad to answer any questions after the panel finishes.

Thank you.

[The prepared statement follows:]

**STATEMENT OF STANLEY JONES, CHAIR-ELECT, PUBLIC POLICY  
COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION**

**INTRODUCTION**

Mr. Chairman, Representative Thomas, and Members of the Committee -- good morning. I would like to thank you for the opportunity to testify on the special needs of people with mental illness for access to health care coverage. My name is Stanley Jones and I am an attorney in Atlanta, Georgia. I am currently Chair-elect of the National Mental Health Association's Public Policy Committee and President of the Mental Health Association of Georgia. My testimony is based on a paper entitled Recommendations for Mental Health Services in Health Care Reform recently sent to Mrs. Clinton's Task Force. It represents the united position of 33 national organizations representing mental health providers, professionals, public agencies and advocates. I ask that the paper be inserted in the Record along with my testimony.

The organizations endorsing the recommendations contend that a continuum of mental health services, including both acute and rehabilitative services, must be an integral part of a reformed health care system which provides access for all Americans. This continuum of services must be available to all adults and children with mental or emotional disorders. Costs should not be limited by restricting the individuals who are eligible under the program.

**MENTAL HEALTH IN HEALTH CARE REFORM**

We support delivery of mental health services through systems of organized care that incorporate sound economic incentives, realistic cost controls and effective quality controls. The systems should hold providers accountable for efficient performance. This approach forms the rationale for including a broad array of mental health services based on medical and psychological necessity in the reformed health care system. The availability of a broad range of covered services reduces inappropriate utilization (and therefore costs) by enabling the system to approve the most effective mix of services for the patient's condition. Costs and unnecessary utilization of mental health services can also be constrained by applying the same cost containment approaches used for other health care services. Capitated premiums, prior authorization and utilization management are all acceptable techniques to limit costs.

Mr. Chairman, inability to pay for care is the most significant barrier preventing access to mental health services in the United States, as significant numbers of persons with mental illness find it difficult, often impossible, to secure needed treatment. Mental health care has been treated differently than care for other conditions in health insurance, often resulting in inadequate or unavailable coverage. For example, although 99% of individuals and their families with private health insurance had coverage for inpatient mental health treatment, only 37% had coverage which was equivalent to that of other illnesses. For outpatient benefits, the coverage limits were even more stringent. While 97% of persons with private health insurance had coverage for outpatient mental health benefits, only 6% had coverage equivalent to coverage for other illnesses. Multiple limits were placed on the number of visits covered, total dollars reimbursed and/or the percentage of allowable charge paid. For services which might be termed less traditional, private insurance covers very little coverage. For example, only a small percentage of covered individuals are covered for partial hospitalization (10.7%).

**PREVALENCE**

Seventeen percent of the population, or 30.7 million American adults have a mental disorder in any one year while 41.4 million (22.5%) have a mental disorder some time during their lives. 7.5 million American children (12% of the population) suffer from mental and emotional disturbances such as depression, autism and attention deficit disorder. Prevalence rates for major mental disorders show substantial numbers of individuals affected in any one year with extremely serious problems:

- Schizophrenia: 1.8 million people (1% of population)
- Manic depression: 1.1 million people (0.6% of population)
- Major depression: 6.4 million (3.5% of population)
- Panic disorders: 1.7 million people (0.9% of population)
- Phobias: 16.2 million people (8.8% of population)
- Obsessive compulsive disorder: 2.9 million (1.6% of population)
- Attention deficit disorder in children: 1-2 million (3-5% of population)

A majority of the 30 million Americans who commit suicide each year suffer from a mental or addictive disorder, and suicide is the eighth leading cause of death in the United States. Nearly a third of persons who are homeless suffer from serious forms of mental illness and prevalence rates of mental illness *increase* among individuals who become homeless. According to the Office of Technology Assessment, only about one-third of the 7.5 million children who need mental health treatment receive it, and many in need may not be getting appropriate care.

### **THE COSTS OF MENTAL ILLNESS**

Concern is often expressed that the costs of mental health services, if fully covered, would be excessive. However, untreated or undertreated mental illnesses cost the United States significantly. Indirect costs of mental illness (lost productivity and earnings due to illness, and lost earnings due to premature death) totaled \$74.9 billion in 1990. Other related costs of mental illness (crime and social welfare costs, incarceration and family caregiving) add up to \$6 billion – more than half of which (\$3.3 billion) is attributable to schizophrenia. This brings the total of indirect and related costs of mental illness to just over \$80 billion.

Total direct costs of mental health treatment, including both public and private expenditures, represent 10% of direct costs of health care in the United States. The National Institute of Mental Health estimates direct treatment costs at \$67 billion in 1990, including \$17.3 billion for schizophrenia (25.8%); \$19.2 billion for affective disorders (28.7%) and \$10.8 billion for anxiety disorders (16%). According to the National Institute of Mental Health, this brings the total direct and indirect costs of mental illness to \$147.8 billion in 1990.

### **THE COST-EFFECTIVENESS OF MENTAL HEALTH TREATMENT**

The failure of the current system to provide appropriate access to mental health treatment does not save money. For example, use of the antipsychotic medication clozapine in the treatment of neuroleptic-resistant schizophrenia results in savings, according to NIMH, of \$18,300 per year/per patient treated. The per patient savings extrapolates to overall annual savings of \$3.7 billion for the estimated 200,000 patients whose course of illness predicts good response to the medication.

A study of anxiety disorders concludes that increased availability of effective and relatively low-cost outpatient treatment could significantly reduce societal and economic costs associated with anxiety disorder. Anxiety disorders affect 27.7 million individuals sometime in their lives. Economic and societal costs were \$46.6 billion in 1990 (\$34.2 billion due to lost productivity resulting from anxiety disorders suffered by non-hospitalized individuals, and \$12.4 billion for direct treatment costs). Treatment is effective, normally provided in an outpatient setting, and relatively inexpensive. Failure to detect panic disorders results in numerous unnecessary angiograms being performed in the U.S with an estimated waste of medical expenditures totalling \$33 billion a year.

NIMH data also show that a combination of interventions, including medication and rehabilitation (social skills training and family therapy), can significantly reduce the relapse rate in a given year for patients with schizophrenia:



Medication alone	-- relapse rate = 38%
Medication + social skills training	-- relapse rate = 30%
Medication + family therapy	-- relapse rate = 23%
Medication, social skills and family therapy	-- relapse rate = 9%

Studies examining the effectiveness of less traditional services demonstrate the importance of the full range of services recommended in the attached paper. Recipients of case management services demonstrate more stable community adjustments than those persons not receiving the services. A model Intensive case management program for adults with severe mental disorders -- Program of Assertive Community Treatment (PACT) -- show that this comprehensive, integrated multidisciplinary treatment team approach to care is more cost-effective than either the hospital-based care or other available community-based care, against which the model was tested.

Based on a review of 35 studies, psychiatric rehabilitation services designed to treat the functional impairments caused by major mental illnesses have been shown to: reduce hospital recidivism and therefore overall treatment costs; increase the individual's earnings in competitive employment and the individual's ability to live independently.

The costs of providing mental health care can also be offset by other savings. The reduction in hospital utilization as patients participate in psychiatric rehabilitation and/or case management services is well documented -- a consistent finding in many studies. Psychiatric rehabilitation services are significantly less costly than inpatient hospitalization. In Maryland, the cost of a hospital bed in a state hospital now exceeds \$100,000 a year; and a bed in a private or general hospital can cost almost twice that amount. On the other hand, a comprehensive array of community treatment and rehabilitation services (including clinical treatment, medication, psychiatric rehabilitation, housing and vocational rehabilitation) costs less than \$50,000 a year.

#### **EMPLOYERS ARE MOVING IN THE RIGHT DIRECTION**

Many large employers have been shifting their coverage of mental health services to include a broad array of benefits, covering less traditional services such as partial hospitalization, psychiatric rehabilitation, case management and Employee Assistance Programs, as well as the more traditional inpatient and psychotherapy. Some examples of these new approaches are:

- McDonnell Douglas Helicopter Company which, in 1989, introduced a managed mental health employee assistance plan which focuses on individualized patient care planning and long-term care management using a selected provider network. Based on a study which projected savings of \$2.1 million over four years, the plan has enabled the company to reduce individual and family health costs, absenteeism and turnover rates. The plan places no constraints on the type of treatment provided. Inpatient, outpatient and intermediary settings are all covered, based on need. The system has enhanced early case finding and easy access to benefits, and has facilitated long-term management of care.

*During the first year, per capita costs declined by 34% as 17% of the covered population used benefits.*

*There was a 50% decrease in psychiatric and a 29% decrease in chemical dependency inpatient admission costs as well as a 47% reduction in average length-of-stay and lower provider payments.*

- First National Bank of Chicago, in 1983, changed its mental health coverage for 17,000 employees in three states so as to expand the range of mental health services covered. The plan, which provides an Employee Assistance Plan/wellness program, expands the mental health benefit to cover more intermediary services without cover-

age limits and includes more generous reimbursement for ambulatory services (85% of outpatient costs) for treatment accessed through an internal employee assistance program, included utilization review procedures. As a result of these changes, inpatient costs were reduced by 50% over five years. Costs have remained steady ever since. Also, while increased utilization raised outpatient mental health costs, overall behavioral health care costs fell by nearly 30% over four years (to from \$1.4 million to \$1 million annually) and have since remained steady.

*The company found that more flexible care was both less expensive and better. Outcomes improve because people aren't entirely removed from the work and family setting.*

- In 1989, Chevron expanded coverage to include a variety of intermediary services such as partial hospitalization, and created an incentive to use ambulatory care. The plan utilizes a specialized provider network and utilization review program. *During the first year of the program, EAP use increased by 60%, there was a 21% decrease in hospital admissions and -- although the benefit covered twice as many lives as the previous year -- total plan costs rose to only \$9.8 million from \$9.2 million.*

- Honeywell has 12,000 domestic employees enrolled in organized mental health systems in a number of communities. The provider organization (a multi-disciplinary group practice) is responsible for creating a system that offers a full continuum of services. The system contains a strong prevention focus, with an employee assistance program to provide early and easy access to services. There is no benefit design and no specified limits on mental health care. The system determines the most appropriate care, and develops a treatment plan which may include diverse levels and modes of care. *Cost containment is achieved through quality and variation controls instead of through denial of care or discounted fees.*

- Digital works with Health Maintenance Organizations to improve provision of care by setting standards for data, financial stability, access, quality and mental health care. Digital does not use rigid benefit limits. *The program works to increase flexibility in meeting the needs of individual patients and to inform the process with data.*

## RECOMMENDATIONS

The attached paper presents our recommendations issued under four main topics: Cost Containment, Full Continuum of Services, Standards for Delivery of Mental Health Services and Relation of the Reformed Health Care System to the Public Mental Health System.

The reformed health care system should ensure that adults and children in need have access to a broad array of health and mental health treatment, rehabilitation and prevention services -- emphasizing treatment in the least restrictive setting which is consistent with the patient's clinical needs.

We suggest that combining the services now described in Medicare and Medicaid produces a suitable and cost-effective range of acute and rehabilitative mental health services. This approach greatly facilitates clear definition of covered services, since terms and descriptions in current law, regulation and guidelines can be used. Special attention should be paid to ensuring that children have access to a comprehensive approach to their mental, psychological and physical health care. We also urge that the benefit package include a comprehensive and regular screening of children for physical, mental and developmental factors, modeled on the Medicaid Early and Periodic Screening, Diagnosis and Treatment program.

The enactment of federal legislation to reform the health care system will not obviate the need for states to play a major role in health care issues. However, the states' role will, of necessity, change since many of the services now financed by states alone, or by federal-state Medicaid funding, will be reimbursed through the new federal system. The paper

points out that states should continue their current roles in licensure and regulation of the health and mental health system. In addition, they must take on new responsibilities which include forming linkages with managed care entities to ensure individuals have access, as needed, to all services provided under the auspices of state mental health authorities (such as residential services and social supports). This might even include negotiated carve-out arrangements for all, or some, of the mental health services covered under the reformed health care system.

Persons with more severe mental illness are at risk of being denied essential services in a health care delivery system based on managed competition. Health care reform should not create a culture in which services are limited or inappropriately denied, or are used too late or inappropriately. The organizations therefore recommend standards for delivery of mental health services (including managed care) to protect the individual's right to the appropriate care of choice.

## **CONCLUSION**

As the data show, there are significant numbers of individuals in need of mental health treatment, treatments are effective (particularly when a wide range of services is made available) and overall costs, as a percentage of the nation's health care bill, are not excessive. Furthermore, failure to treat these disorders results in other unnecessary health care and other costs to society.

Mr. Chairman, thank you once again for the opportunity to share our concerns about mental health in health care reform. At this time, I would welcome any questions you might have.

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# Recommendations for Mental Health Services in Health Care Reform

Endorsed by the following organizations:

American Academy of Child and Adolescent Psychiatry  
 American Association for Marriage and Family Therapy  
 American Association for Partial Hospitalization  
 American Association of Children's Residential Centers  
 American Association of Pastoral Counselors  
 American Association of Psychiatric Services for Children  
 American Counseling Association  
 American Mental Health Counselors Association  
 American Nurses Association  
 American Occupational Therapy Association  
 American Orthopsychiatric Association  
 American Psychiatric Association  
 American Psychological Association  
 American Society for Adolescent Psychiatry  
 Anxiety Disorders Association  
 Center for Victims of Torture  
 Child Welfare League of America  
 Family Service America  
 Federation of Families for Children's Mental Health  
 International Association of Psychosocial Rehabilitation Services  
 Mental Health Law Project  
 National Association of Counties  
 National Association of Developmental Disabilities Councils  
 National Association of Protection and Advocacy Systems  
 National Association of Psychiatric Health Systems  
 National Association of Psychiatric Treatment Centers for Children  
 National Association of State Mental Health Program Directors  
 National Council of Community Mental Health Centers  
 National Depressive and Manic Depressive Association  
 National Federation of Societies for Clinical Social Work  
 National Foundation for Depressive Illness  
 National Mental Health Association  
 Zero To Three

March 5, 1993

\* NAPHS has a more specific proposal, generally consistent with this document.

## **Recommendations for Mental Health Services in Health Care Reform**

### **Introduction**

The 33 national organizations endorsing this document contend that a continuum of mental health services, including both acute and rehabilitative services, is an integral part of a reformed health care system which provides access for all Americans. The range of services must be available to all adults and children with mental or emotional disorders.

Combining the services now described in Medicare and Medicaid produces a suitable and cost-effective range of acute and rehabilitative mental health services. This approach greatly facilitates clear definition of covered services, since terms and descriptions in current law, regulation and guidelines can be used. Methods of containing costs need to be carefully tailored to the services covered, as they are for other conditions. Costs should not be limited by restricting the individuals who are eligible under the program.

We support delivery of mental health services through a system of organized care that incorporates sound economic incentives and appropriate quality controls. The system should hold providers accountable for efficient performance. Such a system forms the rationale for including a broad array of mental health services based on medical and psychological necessity in the reformed health care system. The availability of a range of covered services reduces unnecessary utilization (and therefore costs) by enabling the system to approve the most effective mix of services for the patient's condition.

### **Cost Containment**

The mechanisms used to contain costs of mental health care should be the same as the cost-containment approaches used for other health care services, since these types of controls will be as effective with mental health care as they are for other services. That is, if care is furnished through organized systems, with cost-control limits established, for example, through capitated premiums, prior authorization and/or utilization controls, mental health care utilization can be adequately controlled. The restructuring will remove current incentives to hospitalize individuals and instead encourage care in less expensive, clinically effective settings. Thus, mental health services need no arbitrary limits on amount or duration of care.

Co-payments and deductibles should be set at the same rate as for other health care. An exception to this rule could be psychotherapy, which has been shown to be highly responsive to co-payments. Variable co-payments, which encourage early treatment but discourage unnecessarily extended services, could help control unnecessary utilization of psychotherapy. Other non-mental health services are also similarly price responsive. However, a sliding scale to assist low-income individuals in meeting such co-payments would be necessary, and variable co-payments should not result in individuals with severe conditions being hospitalized because they cannot afford necessary outpatient services.

### **Full Continuum of Services**

The reformed health care system should ensure that adults and children in need have

access to a broad array of health and mental health treatment, rehabilitation and prevention services, emphasizing treatment in the least restrictive setting, consistent with the patient's clinical needs. A narrow benefit (such as one focused on inpatient hospitalization and office-based treatment, as is typical in health insurance policies) is less effective and in the long run more costly, since it would result in some individuals with severe mental illness cycling between inpatient care and private office practice -- suffering more frequent, or more severe, relapses than necessary. A broad array of coordinated acute and rehabilitative services, such as the package described below, would prevent this.

Paragraph (1) below describes a continuum of mental health services which should be financed through the new system; paragraph (2) details a more appropriate approach to children's benefits, which should be covered as well. The system should ensure that individuals have access to these specialized services through an array of state-licensed or certified agencies and professionals. In addition, the system should be sufficiently flexible to incorporate new service approaches as research and experience demonstrate their efficacy and cost-effectiveness.

1) **Mental health services** include the following items and services (as now defined through Medicare and/or Medicaid policy) --

- **Assessment and diagnosis**, with the same co-payment requirements as are imposed for any other health assessment or diagnostic services (current Medicare policy).
- **Emergency services**, 24-hours a day, including crisis intervention in the home, crisis residential services and hospital emergency services (current Medicaid policy).
- **Medication management services**, brief office visits to physicians for prescribing or monitoring medication and assessing patient functioning, similar to visits to physicians for physical illness, with the same co-payment requirements as for any physician visit (current Medicare policy).
- **Other outpatient/ambulatory mental health services**, which include:
  - **Short-term individual, group or family psychotherapy** (current Medicare and Medicaid policy) when furnished by a licensed or certified mental health professional. The services would be subject to utilization management and co-payment arrangements.
  - **Extended psychotherapy**, provided only for patients with conditions which seriously impair their functioning, based upon prior authorization and individual case review at appropriate intervals.
  - **Partial hospitalization** (current Medicare and Medicaid policy) and **psychiatric rehabilitation** (current Medicaid policy), as alternatives to an inpatient hospital day and/or to provide services to restore and maintain functioning for adults and children, with utilization review of necessity and appropriateness of care at appropriate intervals.
  - **Case management services**, for children and adults whose mental or emotional disorders require support services from multiple agencies (current Medicaid policy).
- **Acute hospital services**, to include all types of facilities now currently able to participate under Medicaid, based on a clinical evaluation of the need for inpatient care and subject to periodic utilization management. This benefit should cover services necessary to stabilize the patient's condition and to prepare and implement a plan for discharging the individual to ambulatory services.

Medicare and Medicaid standards should be used to determine certification of facilities, and facilities serving children and adolescents should be required to have specialized units and services for youngsters. In addition, current policy to exclude from reimbursement those facilities run by state governments should be continued, (see page 5 for further explanation).



- **Prescription drugs**, including all medications necessary to treat mental illness. (This broadens slightly the current Medicaid prescription drug benefit, which permits states to exclude from reimbursement some medications necessary for the treatment of mental illness, e.g. Benzodiazepines and drugs used to treat anorexia.)

## 2) Services for Children and Adolescents

It is cost-effective to have a broad-based, comprehensive approach to services for children and adolescents whose mental, psychological and physical health can have a lasting impact upon their development and functioning as adults. The system should encourage provision of child-centered family preservation services to enable children to continue to live at home. Therefore, in addition to the specific mental health interventions described above:

- Children should have coverage for a comprehensive and regular screening of their physical and mental health and developmental factors, modeled on the current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in Medicaid.
- Children identified by the screening process as having current or potential problems should be referred to appropriate child mental health specialists (or if not available, other mental health specialists) for further diagnosis and possible referral for mental health services (as covered in the mental health benefit described above).
- Families should have access to health education programs, focusing on parenting skills and risk-reduction activities.

## Standards for Delivery of Mental Health Services

Persons with chronic illness -- both mental and physical -- are at risk of being denied essential services in a health care delivery system based on managed competition. Review of the experience with Health Maintenance Organizations in providing care for persons with severe mental illness clearly demonstrates that providers operating under capitated premiums have strong incentives to shift treatment responsibilities for expensive patients to the public mental health system. The experience emphasizes the need to protect patients in a managed competition system from being denied services or being shifted into the public system because the cost of their treatment is high.

Health care reform should not create a culture in which services are limited or inappropriately denied, or are used too late or inappropriately. Instead, early intervention should be emphasized.

Standards for delivery of mental health services (including managed care) included in health care reform should:

- Ensure an adequate range of high quality, individualized services provided in the least restrictive setting consistent with the individual's clinical needs.
- Ensure identification and assessment of mental health care needs, so as to ensure early intervention.
- Involve maximum patient/consumer choice in the selection of providers, within the scope of efficient care management standards, and patient/consumer participation in preparation of the treatment plan.
- Ensure confidentiality of patient-provider information.
- Develop quality assurance requirements, including performance-based and consumer satisfaction outcome measures.
- Use reviewers who are licensed or certified in the areas of health care they are reviewing.
- Require publication, in an accessible place and manner, of the review standards

and criteria used in evaluating care plans.

- Prevent conflicts between financial incentives and reviewer decisions.
- Ensure that decisions are made quickly; and
- Establish arbitration or similar hearing arrangements to resolve appeals of the organization's decisions and provide ombudsman services to assist individuals in negotiating the system.

Organized care or managed care entities must also:

- Negotiate linkages with public mental health agencies to ensure that individuals with functional limitations due to severe mental illness have access, as needed, to the multiple services and supports they may need in addition to the mental health services described above and furnished by the organized care system.

### **Relation of the Reformed Health Care System to the Public Mental Health System**

The enactment of federal legislation to reform the health care system will not obviate the need for states to play a major role in health care issues. However, the states' role will, of necessity, change since many of the services now financed either by states alone or by federal-state Medicaid partnerships, will be reimbursed through the new federal system.

Yet extensive state responsibilities will remain, particularly for people with severe mental illness whose full range of needs will not be met even through the array of acute and rehabilitation services described in the services section above. Individuals with severe mental illness often require multiple services and supports which, in turn, will require coordination of and linkage between general health care, mental health treatment and an array of other supports and services such as housing, job training, income support and education.

Individuals with severe mental illness will also need home and community-based long-term care services, which should continue to be financed jointly between federal and state governments, perhaps in the immediate future through a residual Medicaid program.

Roles which *states now perform* with respect to mental health and which should continue under a reformed health care access system include:

- Setting and enforcing standards for service providers.
- Licensing or certifying qualified mental health professionals.
- Developing state-wide plans to meet the broad needs of adults with severe mental illness and children with serious emotional disturbance.
- Developing, operating and/or financing specialized services (such as social programs, residential programs, drop-in centers, etc.) which will not be covered through health care reform for adults and children with severe functional impairments.
- Developing and testing new approaches to mental health service delivery and organization of mental health services.
- Financing services for certain institutionalized populations (forensic care, for example) and mental health services in state-operated psychiatric hospitals for individuals between the ages of 22 and 64, although individuals in such facilities would still be eligible for other covered medical services, e.g. medical and dental care. This recommendation would apply the current Medicaid exclusion of reimbursement for care in "Institutions for Mental Diseases" only to state psychiatric hospitals.

Under a reformed health care system the *federal government* would also need to:

- Address the need for population-based services such as health promotion and prevention.
- Continue its responsibility for needs assessment, data collection, quality assurance, and services and systems research.
- Develop mechanisms to encourage the reinvestment of state mental health resources into community services.
- Stimulate states and communities to develop innovative approaches for delivering mental health services.

Under a reformed health care system, *states might assume new roles*, such as:

- Link with managed competition entities to ensure that individuals with mental illness have access, as needed, to all services provided under the auspices of state mental health authorities (such as residential services and social supports).
- Negotiate to be a managed care provider for mental health services for adults and/or children. Under this "carve out" arrangement, states would commingle their existing financial resources with state Medicaid funds to provide both mental health services financed through the reformed federal health system, and other social services, such as residential services and supports. This option should require states, under a plan approved by the Secretary, to identify the characteristics of individuals to be served and describe the means the state will use to assure access, appropriate service and quality of care.

States which chose to cover children under this option should be required to submit a plan for ensuring that children have access to comprehensive and regular screening (as described above) of their physical and mental health and developmental factors.

- Negotiate with an existing managed care entity to subcontract as a manager of certain mental health services covered through the health care access system for persons with severe mental illness.



Mr. LEVIN. Thank you.  
Mr. Bowers.

**STATEMENT OF MICHAEL BOWERS, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY**

Mr. BOWERS. Mr. Levin and members of the committee, good afternoon. I am Michael Bowers, associate executive director of the American Association for Marriage and Family Therapy. The AAMFT, with a membership of 20,000, is the national association for the profession of marriage and family therapy. AAMFT would like to thank you for this opportunity to testify. We believe that the lack of adequate health insurance coverage has had a tragic impact on millions of American families.

AAMFT is pleased to support the recommendations for mental health services and health care reform described here today by the National Mental Health Association and endorsed by 34 organizations.

In the interest of time, I will summarize specific recommendations which we believe are essential to successful health care reform.

First, we believe that within a standard benefit package on health care reform, there must be a continuum of mental health services included which recognizes the importance of high-quality and cost-effective care, such as outpatient psychotherapy, including family therapy. We believe there is ample evidence for the necessity and effectiveness of such a benefit design, and we believe there is evidence that including outpatient psychotherapy with some of the data that was discussed earlier will not significantly escalate either utilization rates or overall costs.

Researchers are finding that patients, whose families are included in outpatient psychotherapy treatment, are more likely to function independently and with less medical utilization. Marriage and family therapists' work with patients and their families has proven to decrease hospitalization rates among the seriously mentally ill.

Further, family therapy is considered an essential treatment for substance abuse and disorders such as depression, anorexia, bulimia and many other forms of psychopathology. These and other data indicate that inclusion of a continuum of care for the treatment of mental and emotional disorders must be part of a reform system.

Second, the benefit design must not arbitrarily exclude qualified mental health providers such as marriage and family therapists from being eligible to deliver directly reimbursable services. In particular, AAMFT is concerned that a health care reform system modeled after Medicare could inadvertently eliminate groups of qualified providers who are not currently reimbursed under Medicare, but, nonetheless, have become an integral part of the health care delivery system.

The "Recommendations for Mental Health Services in Health Care Reform" proposes a mental health benefits package modeled after a combined set of Medicaid and Medicare benefits. However, the recommendations are clear in their intent to differ from the

current Medicare regulations regarding those providers who can provide these services by explicitly recognizing that consumers should have access to services "through an array of State licensed or certified agencies and professionals."

AAMFT strongly believes that the principle of consumer access to a range of qualified providers, including marriage and family therapists, must be fundamental to health care reform.

Third, as managed care models are proposed as a component of health care reform, consideration must be given to the development of approaches that seek to assure the highest quality of cost-effective service delivery, without neglecting issues of the integrity of the review process and also addressing inappropriate fiscal incentives, claims management issues, and consumer satisfaction.

Some managed care practices have had a history of controlling costs, but a legacy of compromising the quality of care delivered.

AAMFT believes that the health care system must be restructured such that when managed care principles are applied, there are safeguards to guarantee that necessary, appropriate, and high-quality care is being provided, and we expand on this recommendation in our written testimony which we have provided to the committee.

In summary, AAMFT believes that mental health must be part of a standard benefit in a reformed system. Second, we maintain that the mental health benefit must include a continuum of mental health services which recognize medical and psychological necessity, and includes high-quality, cost-effective treatment such as outpatient psychotherapy and family therapy.

Third, the consumers must have freedom to choose among a range of qualified providers, including marriage and family therapists. And fourth, as managed care models are developed, consideration must be given to approaches which seek to assure the highest quality service delivery, cost effectiveness, and integrity in the review process.

AAMFT appreciates this opportunity to share our views and recommendations to the committee. We look forward to continuing our work with you to help shape legislation to reform our Nation's health care delivery system.

Thank you.

[The prepared statement follows:]

**STATEMENT OF MICHAEL BOWERS, ASSOCIATE EXECUTIVE DIRECTOR,  
AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY**

Chairman Stark, Representative Thomas and members of the Committee, good afternoon. I am Michael Bowers, Associate Executive Director of the American Association for Marriage and Family Therapy (AAMFT). The AAMFT is the national association for the profession of marriage and family therapy. Its membership includes marriage and family therapists, and other mental health professionals who have completed graduate and post-graduate training in this discipline. In addition, we have a close working relationship with the California Association of Marriage and Family Therapists (CAMFT) which represents the interests of more than 20,000 licensed marriage and family therapists in California.

AAMFT would like to thank you for this opportunity to testify. We appreciate your efforts to develop a national plan to reform our nation's health care system. The lack of adequate health insurance coverage has had a tragic impact on millions of American families and is an issue which Congress must address comprehensively and compassionately.

AAMFT is pleased to support the "Recommendations for Mental Health Services In Health Care Reform" described here today by the National Mental Health Association, and endorsed by 34 organizations. In addition, we also are pleased to present a series of related recommendations the we believe are essential to successful health care reform.

Specifically, we believe a responsible approach to health care reform must recognize the high cost of ignoring the mental health care needs of the over 40 million American adults and 7.5 million American children who suffer from mental and emotional disorders. A reformed health care system must include a broad range of cost effective and high quality alternatives to traditional approaches to mental health service delivery, which have relied more heavily on inpatient services. It is important that a continuum of care be available with the emphasis on outpatient services, in contrast to other more restrictive and more expensive treatments.

Access to care must be determined based on medical and psychological necessity. AAMFT believes that mental health services, agencies and providers should be subject to the same models of cost containment and utilization review that are applied to health services that stress the quality of care and not just the cost of care. Most importantly, a reformed health care system directly and explicitly must recognize a range of qualified licensed and certified health and mental health professionals, including marriage and family therapists, who have become an integral part of our nation's health care delivery system.

**APPROPRIATE MENTAL HEALTH CARE CAN REDUCE OVERALL HEALTH CARE COSTS**

It has been speculated that adding comprehensive mental health coverage to a basic benefit package will be costly. However, the Congress must understand that not providing these services is even more costly, both in terms of acute and longer-term health care costs and other direct and indirect costs to our society. For example, a recent U.S. Department of Health and Human Services study has estimated that the actual economic costs of mental illness and substance abuse is over \$273 billion. This estimate does not measure the personal pain experienced by



individuals with mental disorders, or their families. In addition, these data do not account for the economic costs of suicide which is the eighth leading cause of death in the United States and one of the leading causes of death among adolescents.

Many studies suggest up to an 80% decrease in health system use following appropriate mental health treatment including family therapy. This phenomena has been identified as the "cost-offset" effect. It also has been estimated that up to 50% of the problems presented by patients to their primary care physicians are behavioral in nature and effectively can be treated by mental health professionals.

These data suggest that comprehensive mental health services are an essential component of the basic services that must be included within every health care plan. Unfortunately, many current health care plans discourage the utilization of cost-effective mental health services because of a benefit design which favors inpatient services, the most expensive form of treatment. Approximately 80% of the funds expended for mental health care are spent on inpatient services. An impressive and growing body of research supports the efficacy of alternative treatments - most notably short-term outpatient psychotherapy, including family therapy. Members of Congress, and those who are developing models to reform the health care system, must recognize this growing body of research and the availability of cost-effective alternatives for mental health service delivery.

For example, inpatient care often is used to treat seriously emotionally disturbed children and adolescents, when in many cases, outpatient care involving families may be more appropriate, and much less expensive. The inpatient costs for one month of treatment of a child or an adolescent in a psychiatric hospital can be up to \$25,000. This expenditure would pay for many more episodes of care when treatment, including family therapy, is provided on an outpatient basis. For example, an episode of care provided by a marriage and family therapist typically lasts less than 20 sessions. Even for cases where illnesses are very severe, requiring more intensive treatment, costs remain much less when family therapy is included as an integral component of the overall treatment plan.

The development and widespread acceptance among researchers and clinicians of family therapy as a critical treatment for intervening with an array of mental and emotional disorders has helped to foster the rapid evolution of the practice and profession of marriage and family therapy. Family therapy is considered an essential treatment for alcoholism, substance abuse, chemical dependency, and other addictive disorders that represent a very prevalent and costly set of problems in our society. In addition, the treatment of major mental illnesses, including schizophrenia and other major affective disorders, depression, anorexia, bulimia, other eating disorders, and many other forms of psychopathology often typically includes family therapy.

Researchers are finding that patients whose families are part of the treatment plan are more likely to function independently and with less medical utilization. For example, marriage and family therapists' work with families has proven to increase significantly the time seriously mentally ill patients spend outside of the hospital, when compared to patient re-admission rates prior to treatment. Studies also have found that re-hospitalization rates for schizophrenic patients have substantially been decreased when family therapy had been included within the treatment plan. In one study, relapse rates were reduced for 77% of patients with manic depressive or schizoaffective psychoses after receiving brief family therapy. One half of the patients in this study were able to function without major medication three years later.

AAMFT believes that outpatient psychotherapy, including family therapy, provided by appropriately trained mental health professionals such as and including marriage and family therapists, must be an integral component and required benefit of a standard package of services that will be identified as an element of health care reform.

## OUTPATIENT MENTAL HEALTH COSTS HAVE REMAINED STEADY WITH COMPETITION

Outpatient mental health treatment unit costs have remained relatively steady with increased competition among qualified mental health providers. Congressionally sanctioned competition among a range of qualified mental health care providers, including marriage and family therapists, has not affected the unit cost or quality of services provided.

At the request of Congress, the Office of Personnel Management (OPM) recently completed a study on expanding freedom-of-choice for non-medical health care providers within the Federal Employees Health Benefits Program. In this study, OPM noted that the fear:

"...of greatly increased benefit utilization and costs...have not been realized...Historically, OPM...along with other major insurance carriers, have argued that mandating coverage of additional categories of providers would lead inevitably to an increase in utilization, and hence drive up program costs...OPM can no longer support this view ...We no longer are prepared to argue that should Congress decide to mandate coverage of alternative practitioners, such action would inevitably have serious, deleterious consequences..."

AAMFT is concerned that those individuals and families most in need of health and mental health coverage have access to available and affordable health and mental health care. Certainly, the history and economics of health care have borne witness to the fact that freedom-of-choice statutes are pro-competitive and do not significantly increase cost or compromise the quality of care that is provided. Marriage and family therapists, and other qualified mental health professionals, provide necessary psychotherapy services that are both cost-efficient and effective. AAMFT believes that specific language must be included within developing health care reform legislation that would assure consumer access to a wide range of qualified mental health professionals including marriage and family therapists.

Since 1966, marriage and family therapists have been authorized as providers under the large federal CHAMPUS program. Marriage and family therapists have provided high quality and well regarded services to these federal beneficiaries for over 25 years. The federal recognition of this profession was further codified by the Congress in 1988 when marriage and family therapy was designated as one of the five federally recognized "core" mental health professions.

The private sector marketplace also has embraced marriage and family therapists. These mental health professionals have been included in most major national, regional and local health insurance programs. In regard to self-insured employee benefit trusts, many large corporations routinely provide direct reimbursement to marriage and family therapists. In addition, a recent AAMFT survey of the managed behavioral health care industry indicates that marriage and family therapists also typically are included on provider panels and among referral networks used by employee assistance programs.

## THE NECESSITY OF A "LEVEL PLAYING FIELD" FOR ALL QUALIFIED PROVIDERS

AAMFT believes that it is imperative that a "level playing field" exist among all competing providers in the mental health community, including marriage and family therapists. Our association believes that this can be achieved by structuring federal policy, as it relates to the reimbursement of mental health care providers, so that marriage and family therapists and other qualified mental health professionals are directly reimbursed routinely and consistently as a matter of federal policy.

State licensing or certification should be used as one method to determine which marriage and family therapists and other mental health care providers are eligible to receive direct reimbursement. That is, in those states which license or certify these providers, the provider should be eligible for direct reimbursement if he or she is licensed or certified by the state. Thirty states currently regulate the profession of marriage and family therapy.

In states where there is no regulation at the present time, there are recognized alternative methods for establishing the qualifications of mental health providers. For example, currently in federal law the services of clinical social workers are recognized specifically when a clinical social worker resides in a state which does not license or certify the profession of clinical social work but when such an individual is recognized by an appropriate national credentialing organization.

A similar system exists for determining qualified professionals in marriage and family therapy. AAMFT administers a careful system for evaluating applicants seeking the status of "Clinical Member" in the Association. The standards for obtaining AAMFT Clinical Membership are as rigorous as the requirements for state licensure or certification. In order to become a Clinical member of AAMFT, a professional must complete a master's or doctoral degree in marriage and family therapy from a regionally-accredited educational institution, or an equivalent course of study and degree. Following receipt of a qualifying degree, completion of two calendar years of work experience in marriage and family therapy under approved supervision also is required. This clinical experience involves successful completion of at least 1,000 hours of direct clinical contact with couples and families, and 200 hours of direct supervision of that work - at least 100 hours of which must be in individual supervision.

#### DEFINITION OF A QUALIFIED MARRIAGE AND FAMILY THERAPIST

AAMFT recommends the following language for defining a qualified marriage and family therapist:

"A marriage and family therapist shall be an individual who:

1) possesses a minimum of a master's degree; and

2) has completed not less than two years of supervised clinical experience; and

3) (A) is licensed or certified by a State regulatory agency as a "marriage and family therapist," "marriage, family and child counselor," or under a similar title, so long as the State regulatory agency specifically licenses or certifies such providers; OR

(B) in the case of an individual in a State which does not provide for licensure or certification is eligible for clinical membership in a national professional association that provides such a credential for marriage and family therapists, as determined by the Secretary."

#### MEDICARE AS A MODEL FOR HEALTH CARE REFORM

AAMFT is concerned that a health care reform system modeled after Medicare could inadvertently eliminate groups of qualified providers who are not currently reimbursed under Medicare, but nonetheless have become an integral part of the health care delivery system. For example, we believe that it would be unfair and arbitrary to eliminate marriage and family therapists as mental health providers from a standard benefit package within a health care reform rubric when other related mental health professionals - including psychologists and social workers - only became reimbursable Medicare providers in legislation passed in 1989.



The "Recommendations for Mental Health Services in Health Care Reform" cited earlier, and endorsed by the 34 organizations, proposes a mental health benefit package modeled after a combined set of Medicaid and Medicare benefits as a template for an appropriate range of comprehensive mental health benefits. However, the recommendations are clear in their intent to differ from the current Medicare regulations regarding those providers who can provide these services by explicitly recognizing that consumers should have access to services "through an array of state-licensed or certified agencies and professionals." AAMFT strongly believes that the principle of consumer access through freedom-of-choice must be fundamental to health care reform.

#### MANAGED CARE: A CONCEPT REQUIRING REFINEMENT

AAMFT is concerned about the increasing congressional attention to and support for mandating managed care as a "magic bullet" solution to controlling health care costs. Managed care practices have a history of controlling costs, yet also have a legacy for compromising the quality of care delivered. AAMFT believes that the health care system must be restructured such that when managed care principles are applied there are safeguards to guarantee that necessary, appropriate and high quality care is being provided. AAMFT also believes that utilization and professional services review, as well as related appeals, must be conducted by similarly-trained professionals to the provider providing the service being reviewed. Providers and consumers also must have full access to management criteria and consumers must be free to select their personal provider from a range of providers, including marriage and family therapists. A uniform system of claims management, including consumer satisfaction information, also should be implemented. Consumer protection from financial conflicts of interest held by providers (ie. rewards tied to low referrals and utilization of services) is essential.

#### RECOMMENDATIONS FOR HEALTH CARE REFORM

In summary, AAMFT makes the following four major recommendations:

- 1) Mental health services must be included as part of the standard benefit package of the nation's health care reform plan consistent with the "Recommendations for Mental Health Services in Health Care Reform."
- 2) The standard benefit package must include a continuum of mental health services that recognizes the importance of medically and psychologically necessary, high quality and cost-effective alternatives to inpatient care such as outpatient psychotherapy including family therapy.
- 3) Marriage and family therapists, as defined using AAMFT's suggested definition, and other qualified mental health professionals, must be eligible to receive direct reimbursement and to participate fully as independent providers of mental health services within a reformed health care delivery system.
- 4) As managed care models are considered as a component part of health care reform, consideration must be given to the development of approaches that seek to assure the highest quality of cost-effective service delivery with attention to issues of the integrity of the process, claims management, and consumer satisfaction.

AAMFT appreciates this opportunity to share our views and recommendations with the Committee. We look forward to continuing to work with you to help shape legislation to reform our nation's health care delivery system.

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Mr. LEVIN. Thank you.  
Mr. Trachtenberg.

**STATEMENT OF ROBERT L. TRACHTENBERG, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS**

Mr. TRACHTENBERG. Mr. Chairman and members of the subcommittee, my name is Robert Trachtenberg. I am the executive director of the National Association of Psychiatric Health Systems, formerly the National Association of Private Psychiatric Hospitals. I am very pleased to have this opportunity to testify before the committee.

Responding to the challenge to develop cost-conscious, yet workable strategies for mental health care reform, our association has adopted a comprehensive mental health care reform proposal. The proposal goes far beyond the discussion of traditional hospital issues and presents a strategy for affordably covering all medically necessary psychiatric treatment in the full range of treatment settings.

Through capitation and other cost controls, the plan offers an alternative to current systems that arbitrarily limit mental health benefits. Based on organized delivery systems of care, the plan provides incentives for patients to receive a level of care they need in the most appropriate setting. We must begin to define patient care by results, and not by a particular modality or a particular setting.

The NAPHS plan is designed to be part of an overall restructuring of the entire health care delivery system. It emphasizes the importance of putting mental health practitioners in charge of mental health treatment that can accommodate public and private patients, and indeed it could accommodate a blending of the public and private patients into one system, and it offers access to all types and levels of treatment settings.

The NAPHS proposal provides specific solutions to current roadblocks to getting patients the mental health care they need. To effectively address the problems of accessibility and fragmentation, lack of coordination, lack of accountability, overutilization and high cost, and poor benefit coverage of current services, the association's plan provides for the following: Eliminating specific arbitrary benefit limits and covering all medically necessary care; providing payment for a full continuum of treatment services and determining treatment on outcome and effectiveness, rather than on whatever setting happens to be available or is reimbursable; and reemphasizing the role of clinicians and patients in determining the type and appropriate level of care according to a patient's individual need.

To insure quality, the plan calls for first creating federally qualified integrated psychiatric service networks. Federal qualifications would insure that the groups who provide the coordinated care meet criteria to provide quality care. Second, provide public accountability by requiring disclosure of outcome data and evaluation of providers.

To improve access, the plan calls for the eliminating of preexisting condition restrictions, permitting portability of coverage and requiring community rating.



To control costs and utilization, the plan calls for first defining the mental health benefit as a percentage of the standard benefit package, so the premium costs will not exceed a defined amount. At the same time, Federal qualifications for the integrated psychiatric service networks would ensure that systems are set up to provide adequate care.

Second, promoting provider accountability and improved productivity through capitated or other risk-sharing arrangements. Third, promoting responsible consumer decisions through cost sharing that would vary based on types of services and economic status. And fourth, offering a single entry point through diagnostic and referral centers to ensure appropriate use of services and to avoid undertreatment.

In summary, we believe our proposal is a realistic plan that supports the basic principles of equitable mental health coverage long advocated by this association and the mental health field. At the same time, we make concessions to new and hopefully more workable systems for delivering care.

Health care reform inevitably will mean change and sacrifice. All participants throughout the system must rethink what is essential to maintaining basic health care. The greatest challenge for the mental health community and the Congress and other policymakers will be building workable proposals that provide patients with the care that they medically need, but perhaps not all the care that they may want.

We recognize that you and the administration face very tough choices. We want to work closely with you and the other members of this subcommittee in order to shape a mental health plan that meets the needs of patients, is fair, and is cost-effective.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF ROBERT L. TRACHTENBERG, EXECUTIVE DIRECTOR,  
NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS**

Mr. Chairman and members of the Subcommittee, my name is Robert L. Trachtenberg; I am the executive director of the National Association of Psychiatric Health Systems (NAPHS), formerly the National Association of Private Psychiatric Hospitals. On behalf of NAPHS, I want to thank you for this opportunity to testify before the Ways and Means' Health Subcommittee on the types of benefits that should be included in a standard benefit package in a healthcare reform plan.

To better reflect a membership that offers an entire continuum of patient-centered psychiatric services, we have become the National Association of Psychiatric Health Systems. NAPHS represents the nation's specialty psychiatric healthcare organizations--hospitals, residential treatment centers, and partial hospitalization programs--providing medically directed treatment for people of all ages with mental illnesses. Founded in 1933 as the National Association of Private Psychiatric Hospitals, NAPHS today represents more than 300 member organizations throughout the United States.

Today, I want to discuss with the subcommittee the reasons that mental health coverage should be an integral part of any healthcare reform plan and our organization's proposal to establish a medically necessary mental health benefit that would ensure high-quality, appropriate care in the least restrictive, least costly setting to meet the specific needs of all Americans suffering from mental illnesses.

**The Need to Focus on Mental Health**

Mental illnesses affect 31 million American adults and nearly 14 million children and adolescents. In any one-year period, that means 17% of American adults are directly affected by some type of mental disorder. When substance abuse disorders are included, the number of adults affected grows to 22% of the population, or 40 million adults. This figure is comparable to rates for "physical disorders" when similarly broadly defined; eg. respiratory disorders affect 50% of adults, and cardiovascular diseases 20%.

Of those with mental disorders, less than 7 percent of all adults have symptoms for a full year or longer. Between 2 and 3 percent of all adults--some five million in a one-year period--experience severe mental disorders that hamper their daily lives.

The total economic cost of alcohol, drug, and mental disorders is projected to be at least \$273.3 billion. One-fourth of this cost (or approximately \$69 billion) is treatment-related. Three-quarters of the economic impact is the result of lost and reduced productivity, death, accidents, fires, law enforcement, and related costs.

Beyond the economic costs are the devastating human costs. Suicide is the eighth-leading cause of death among all age groups in the United States--with a rate of 12.5 per 100,000. According to the Mental Health Policy Resource Center, mental illness is the third most limiting--in terms of ability to perform a major daily activity--of all disabling diseases, behind only cancer and stroke. When disability is considered in the context of ability to work, mental illness is the most limiting disease. More than three-quarters (76%) of those whose disability is attributed solely to mental illness are unable to work.

In addition to the economic and human costs of mental illnesses, we need to also focus on the efficacy of treatment for these illnesses. Although many Americans and policymakers may be unaware, there have been numerous studies

that have demonstrated that mental illnesses can now be diagnosed and treated as precisely and effectively as are other disorders in medicine. For example, treatments for major depression are successful 65% of the time, while angioplasty treatment for cardiovascular disease is effective 41% of the time. There are many other similar examples that can be cited.

Although some mental health benefits are available to nearly all employees through existing health plans, mental health coverage is commonly subject to special and substantial limitations in the current healthcare system. Fewer days' coverage or annual or lifetime ceilings are more likely for mental illnesses than for any other illness, and limits are more often arbitrary than dictated by medical necessity.

Those in need of mental health services who have no insurance (some 37 million Americans) or inadequate insurance must try to access public services, which often have long waiting lists. Or they simply go without care. Because serious psychiatric and emotional disorders do not go away by themselves, in fact, if left untreated they often get worse, those most in need of help often end up in juvenile detention centers, jails, or hospital emergency rooms, where care is most expensive and not necessarily appropriate.

#### **Mental Healthcare Reform**

In developing a mental health benefit as part of a basic healthcare package, we must not only focus on the benefit design, but also on the ways in which the services would be delivered and financed. A comprehensive approach to mental health coverage is critical in order to provide appropriate, high-quality care in the least costly setting. Because the present system so severely restricts access to psychiatric treatment via arbitrary limits and exclusions designed into benefit plans, reform is especially needed for better coordination, delivery, and financing of mental health services.

Healthcare reform inevitably means change--and sacrifice. All participants throughout the system must rethink what is essential to maintaining basic health care. The greatest challenge for the mental health community and policymakers will be building workable proposals that benefit patients from wish-lists of ideals.

The National Association of Psychiatric Health Systems has adopted *A Comprehensive Mental Health Care Reform Proposal*. We believe this is a realistic plan that supports the basic principles of equitable mental health coverage long advocated by the association and the mental health field while making concessions to new--and hopefully more workable--systems for delivering care. At the core of our proposal is the recognition that:

- \* Major changes in the nation's healthcare system are necessary and inevitable.

- \* Psychiatric hospitals have been evolving into mental healthcare systems that offer services all along the continuum of care.

- \* Market-based reform is more effective than a government-controlled, price-setting system.

- \* Mental health care will not be well-served unless given explicit attention. The NAPHS proposal builds on existing proposals--such as managed competition--but ensures a distinct and specific role for psychiatric care.



## The NAPHS Comprehensive Mental Healthcare Reform Proposal

The National Association of Psychiatric Health Systems' *Comprehensive Mental Healthcare Reform Proposal* addresses the unique needs of millions of Americans who suffer from mental illnesses by establishing a benefit that provides maximum flexibility and a delivery system that provides mental health services effectively and efficiently. A market-based approach will ensure access to the most clinically appropriate, cost-effective psychiatric care.

So that Americans have access to high-quality, cost-effective mental health services, we propose the following changes in the delivery and financing of psychiatric treatment:

- \* Establishing a mental healthcare benefit--defined as a percentage of the standard benefit package--that covers medically necessary psychiatric treatment along the full continuum of services.
- \* Providing incentives for the development of integrated psychiatric services networks that must be federally qualified to deliver mental health treatment.
- \* Paying federally qualified integrated psychiatric services networks according to capitated or other shared-risk arrangements.
- \* Requiring various cost-sharing requirements--such as higher copayments--for services with greater demand-response so that consumers will have sufficient incentive to avoid overuse of mental health services.
- \* Requiring outcome studies from each integrated psychiatric services network that will be made public and, therefore, influence consumer choice.
- \* Reforming health insurance practices, including eliminating preexisting-condition clauses, allowing portability of insurance coverage, and requiring community rating.

The NAPHS plan has three key components: the benefit design, the delivery system, and cost-controls.

First, it is critical that barriers to mental health care be eliminated. Rather than setting arbitrary limits on coverage, the NAPHS proposal would establish a benefit based on medical necessity. The proposal would also require that a full continuum of services be made available including early intervention, crisis intervention, outpatient and intensive outpatient treatment, partial hospitalization, residential treatment, inpatient hospitalization, medical management, and in-home care. The combination of benefits for medically necessary treatment and availability of a full continuum of care would allow patients to receive the most appropriate care in the least restrictive, least costly setting to meet their individual needs.

Second, there must be incentives for coordinating care. Without changes in the delivery system, a benefit based on medical necessity providing access to a broad range of covered services could lead to overutilization of services and an inefficient and costly benefit. Therefore, our proposal would provide incentives to develop organized systems of care--integrated psychiatric services networks--that would be federally qualified to deliver mental health services. These networks could be established through various arrangements, including joint arrangements between insurers and providers, or hospitals and other individual

each of these networks would be a requirement that diagnostic/referral centers be established as part of each network to provide evaluation, assessment, diagnosis, and referral to the appropriate level of care.

NAPHS believes that in order to ensure that persons suffering from mental illnesses truly have access to high-quality, appropriate, cost-efficient care, there must be some basic requirements (federal qualifications) any organization providing mental health services would have to meet to deliver mental health services. These federal qualifications and criteria will reduce misdiagnosis and undertreatment, both more likely when mental health services are delivered through a general healthcare system. Those needing psychiatric care will have access to a system dedicated exclusively to providing appropriate, specialized, high-quality treatment that meets their individual needs.

An NAPHS Task Force is currently reviewing draft federal qualifications, and we will provide this information to the subcommittee when it is completed. We would like to continue to work with this subcommittee, other congressional committees, and the Clinton administration in developing the necessary criteria to ensure that mental health services are delivered in a high-quality, appropriate, and cost-effective manner.

Our proposal would allow federally qualified integrated psychiatric services networks to be part of general healthcare networks, to subcontract with general healthcare networks, or to directly contract with employers. We believe that in a market-based system, where access to cost-effective, high-quality mental health services is the goal, it is essential to allow consumers as many options as possible, including choosing a mental health benefit package from competing federally qualified integrated psychiatric services networks.

Third, we believe any realistic proposal must have cost controls as an integral part of the overall plan. The NAPHS plan directly deals with the issue of cost. The cost control proposal has three aspects: establishing the mental health benefit as a percentage of the standard benefit package; paying the networks on a capitated or shared-risk basis; and requiring differential copayments and deductibles for various types of services.

We recognize that some may argue that a benefit based on medical necessity that covers a broad range of services could be too costly. To address this concern, the NAPHS plan would set a limit on the amount of premium dollars that would be allocated to the mental health benefit based on a fixed percentage of the overall standard benefit package. For example, if the standard mental health benefit were 10% of a standard benefit package costing \$3,000 annually for an individual, \$300 would be available for the mental health benefit. Within that amount, the market will determine which federally qualified integrated psychiatric services network will receive a capitated payment for mental health services for a covered-enrollee population. In setting the mental health percentage, it is critical that the amount made available for mental health coverage is adequate to meet the needs of the capitated population and to allow for high-quality, effective treatment. If too low, the mentally ill will continue to suffer from inadequate attention to the illnesses that have a dramatic impact on individuals, families, and society as a whole.

Our proposal also addresses the cost issue by paying the

networks on a capitated basis and establishing cost-sharing requirements that would vary based on the type of services provided. Certain mental health services have a higher demand response than others, and cost-sharing requirements should take this into consideration. However, the variable cost-sharing requirements should not impair entry into the system. Instead, they should encourage consumers to be careful purchasers of services. Cost-sharing requirements should not be a barrier to care for low-income persons or persons with severe mental illnesses.

#### Summary

Federal qualifications for integrated psychiatric provider networks and adequate mental-healthcare payments based on capitated or other risk-sharing arrangements will create cost accountability and ensure the most appropriate level of care, within a coordinated system, for an individual patient's specific needs. The combination of a "medically necessary" benefit--a percentage of the standard general-healthcare benefit package rather than an arbitrarily designed employer-sponsored package--and federally qualified diagnostic and referral centers will leave patient-placement decisions up to physicians and mental health professionals. And if the percentage of the standard benefit package allocated for medically necessary mental health services is adequate to meet the needs of the capitated population and to permit high quality, cost-effective treatment, this restructured delivery system will be capable of serving all Americans requiring mental health care.

Thank you for giving our organization an opportunity to testify before the subcommittee today. We want to continue to work with you and other members of Congress to craft a mental health benefit that both meets the needs of patients and is cost-effective.

I would be pleased to answer any questions you or other members of the committee may have at this time.



Mr. LEVIN. Thank you.  
Mr. Diehl.

**STATEMENT OF EDWARD M. DIEHL, MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS, AND PRESIDENT, SEABROOK HOUSE, SEABROOK, N.J.**

Mr. DIEHL. Thank you.

My name is Edward Diehl and I am president of Seabrook House, a freestanding center for the treatment of alcoholism and drug dependency in Seabrook, N.J.

My testimony today is on behalf of the board of directors of the National Association of Addiction Treatment Providers, which represents more than 450 private sector alcoholism and drug dependency rehabilitation programs and the patients they serve. Member facilities offer inpatient, residential, and outpatient treatment in hospital-based and freestanding settings.

We endorse the need for specific coverage for alcoholism and drug treatment in any national health care reform which would establish a standard or uniform health benefit package for all Americans. Treatment for alcoholism and drug dependency works. For treatment to work for all Americans, integral levels of care should be included in a basic benefit package. They are: diagnostic assessment and intervention services, detoxification services, residential treatment, partial hospital or day treatment and other outpatient services as needed.

We believe that the treatment for alcoholism and drug dependency should be a separately stated benefit and not subsumed under another category of benefits, such as mental health. Treatment eligibility should be based on competent diagnosis of these diseases and the use of objective patient placement criteria such as those developed by the American Society of Addiction Medicine.

We need managed care applied fairly, patient placement criteria used by payers and providers alike. We must level the playing field in the best interests of our patients. Addiction treatment patients need a comprehensive benefit and objective patient placement criteria which is uniform and guarantees access. Uniform patient placement criteria drives fairness into the treatment system and provides consumer protection to prevent managed care organizations from denying access unreasonably.

Finally, the experience of our field in the last 10 years, as we move through the war on drugs, has been paradoxical, at best. We have experienced a decade of recognition that prevention and treatment works. Yet, financial resources have been disproportionately allocated to interdiction and other unproven prevention projects.

We need to shift our resources more to prevention and treatment for chemical dependency, by providing an appropriate alcoholism and drug dependency benefit for all Americans and insuring access to that treatment.

I think what is most key in my written statement, Mr. Chairman, is the issue of access. As a provider of chemical dependency treatment in a small southern New Jersey facility, we have experienced a move from the days where we were able to help people who had chemical dependency and addiction problems. Today we are on

the verge, as an organization, of going out of business, because of the unwieldy application of managed care, which is truly not managed care at all, but managed costs. Essentially what has been done in the addiction treatment field is that the payers have redefined what addiction truly is, not the description used by clinicians who practice the care and treatment of alcoholism and chemical dependency.

So what I would ask sincerely, on behalf of the providers of addiction treatment represented in our association, is that wherever we go in this journey with health care reform, that the issues of access are considered very seriously, as we assume that managed care will be part of any reform plan.

Thank you.

[The prepared statement follows:]

**STATEMENT OF EDWARD M. DIEHL, PRESIDENT, SEABROOK HOUSE,  
SEABROOK, N.J., ON BEHALF OF THE NATIONAL ASSOCIATION OF  
ADDICTION TREATMENT PROVIDERS**

Good Morning, Mr. Chairman and Members of the Subcommittee.

My name is Edward Diehl. I am President of Seabrook House, a free standing center for the treatment of alcoholism and drug dependency in Seabrook, New Jersey.

I appear before you this morning as a member of the Board of Directors of the National Association of Addiction Treatment Providers - NAATP - which represents more than 450 private sector alcoholism and drug dependency rehabilitation programs and the patients they serve. Member facilities, both for-profit and not-for-profit, offer inpatient, residential and outpatient regimens in hospital based and free-standing settings.

I am here today to speak with you on the need for specific coverage for Alcoholism and Drug Treatment in any National Health Care Reform which would establish a standard or uniform health benefit package for all Americans.

Comprehensive national health care reform offers the opportunity to, once and for all, integrate humane and appropriate addiction treatment benefits and services into an effective system that will provide necessary and appropriate health care for all Americans. National Health Care Reform must include coverage for the treatment of alcohol and drug dependency that is comprehensive and includes services across a continuum of care which affords the least restrictive and/or most appropriate setting for the individual.

Coverage for alcohol and drug dependency conditions should provide for a continuum of diagnostic treatment and rehabilitative services including, but not limited to the following:

- Diagnostic assessment and intervention services
- Detoxification services.
- Residential and/or inpatient treatment.
- Outpatient and day treatment.

Moreover, the following principles, at a minimum, should be adhered to in designing the foregoing coverage:

- Primary care and specialty treatment for alcoholism and drug dependency should be a separately stated benefit and not subsumed under another category of benefit such as mental health.
- Treatment eligibility should be based on competent diagnosis of these diseases by use of objective criteria, and on individual psychosocial needs and medical necessity with appropriate and objective review thereof.
- Patient placement should be based on objective criteria (such as those developed by the American Society of Addictive Medicine) with appropriate and objective review thereof.
- Coverage should be nondiscriminatory and offered on the same basis as any other medical care with benefit limits the same as those for any other chronic condition or disease.

There are many reasons why we support the inclusion of a specific and separately stated benefit for treatment of these illnesses under any uniform benefit package established by national health reform.

First and foremost, drug dependency and alcoholism are among our nation's leading health problems. Approximately 6.5 million individuals require treatment for a drug problem, and as many as 22 million Americans are alcoholic and/or suffer from alcohol-related



problems. The incidence and prevalence of the diseases rank third among the nation's major health problems. They are primary diseases which produce serious secondary physical and psychiatric complications.

People do not choose to become dependent on alcohol and drugs; they become addicted. In this regard, we believe that reimbursement for treatment of these problems should no different from reimbursement for treatment for health care services for other conditions that require health services: diabetes, heart disease (which may be related to lack of exercise, bad eating habits or stress), obesity or pregnancy.

Alcohol and drug dependent persons should not therefore be discriminated against or denied benefits by insurance companies because of their illness.

Moreover, these diseases cause great human suffering and often impose substantial costs in terms of criminal activity, foster care and lost productivity. And, they are directly linked to many costly health problems including fetal alcohol syndrome, cardiopulmonary disease, cirrhosis, and injuries resulting from vehicular accidents and other alcohol and drug related incidents.

We as a society need not shoulder these staggering costs. Drug dependency and alcoholism are highly treatable diseases if comprehensive services are tailored to an individual's needs and are provided at the time an individual seeks services. Providing treatment is far less costly than the price being paid now for treating drug and alcohol related problems in emergency rooms and other hospital beds, incarcerating individuals with drug and alcohol problems, caring for children affected by maternal drug and alcohol use and treating individuals with HIV disease and other health problems.

Our nation will lose a golden opportunity to trim health and other social costs if a comprehensive drug and alcohol treatment and prevention benefit is not included in national health care reform.

Second, inclusion of coverage for these illnesses would be consistent with the prevailing practice of the overwhelming majority of American employers who presently provide health insurance coverage for their employees and their dependents. The most recent data available from the Bureau of Labor Statistics shows that nearly 97 percent of those participants with employer-sponsored health plans had coverage for the treatment of alcohol and drug conditions. Hence, to include coverage for alcohol and drug conditions under any national health reform would be consistent with current private sector practice.

Third, as alluded to earlier, significant evidence has mounted on the relationship between alcoholism and drug dependency and other medical, psychology and social problems. Alcoholism and drug treatment of these conditions significantly reduces overall health care utilization and the associated costs.

Studies indicate that drug and alcohol abusers and their family members are subject to a wide range of physical and psychological problems caused by or related to the excessive use of drug and alcohol, and utilize health care services at a rate far exceeding that of the general population. Untreated alcohol and drug patients use an extraordinarily high number of hospital days for other diagnoses typically related to drug and alcohol abuse.

A Blue Cross study illustrates this overwhelming high utilization of services by persons admitted as drug and alcohol patients:

- These patients have 6 times more admissions for non-substance abuse problems than do the general population, use over 12 times as many hospital days, and often stay in the hospital over twice as long per admission and incur approximately 7 times as much in hospital charges.
- Members of these patients' families also have higher hospital utilization rates than the general population; i.e., approximately 30% more admissions than the general population, use nearly twice as many hospital days and tend to stay in the hospital longer per admission.

Treatment intervention dramatically reduces these costs. The average monthly non-drug and alcohol inpatient charge for drug and alcohol patients increases during three years prior to treatment, peaking during the first month post-treatment and dropping quickly in the second month. The same Blue Cross Study shows the following:

- Three years prior to treatment, average monthly charges for persons with a substance abuse hospitalization was \$50 per month, reflecting a 50% higher occurrence of inpatient hospital charges per month from the overall population.
- From 24 to 12 months before treatment the difference becomes even more pronounced. The average charges per month rise to nearly \$100, and in the year prior to treatment they continue to climb, peaking at \$200 the month prior to drug and alcohol treatment. This increase in inpatient hospitalization in the three years before drug and alcohol treatment indicates that psychological and physiological problems accrue to individuals who continue to abuse alcohol and drugs, and begin to manifest themselves in hospital admissions shortly before drug and alcohol treatment.
- Immediately following treatment, the average monthly inpatient charges increase to \$1,246 the first month, but then immediately drop by 63% to \$464 a month in the second month. By the third month, they decline another 48% to \$243 a month. A continuous gradual decline ensures throughout the following two years. During the third year post treatment, medical surgical average charges increase slightly.

Alcohol and drug dependency are also costly in ways that are not directly tied to health care services. According to reports from the Alcohol, Drug Abuse and Mental Health Administration the costs to society of these diseases are in the billions of dollars. The total amount expended for treatment of these disorders was less than 4% of the total. Effective treatment of drug dependency can also reduce indirect costs to individuals, employers, and communities by reducing family upheavals, domestic violence, absenteeism from work, low productivity, industrial accidents and crime.

There is a large, direct cost to the insurance industry in non-health insurance lines due to alcohol and substance abuse. One study estimate shows that alcoholism and drug dependency raises insurance costs at least \$50 billion annually in the United States.

The provision of alcohol drug dependency treatment benefits will, in the long term, reduce health care and derivative costs and save money for insurers, subscribers and society at large in numerous ways directly and indirectly related to health care costs.

For the foregoing reasons, any standard benefits package developed as part of national health care reform should provide coverage for the treatment of alcoholism and drug dependency.

Diagnostic, treatment and rehabilitative services should be available and accessible across a continuum of care in the least restrictive and/or most appropriate setting for the individual. Coverage should be consistent with the principles outlined herein.

On behalf of the NAATP and the millions of individuals affected by these illnesses, we want to thank you for the opportunity to present our views on this most important issue.

We would be happy to provide any additional information the Subcommittee may be interested in, to answer any questions you may have and/or to elaborate on the alcoholism/drug dependency treatment benefit we advocate.



Mr. LEVIN. Thank you.  
Rev. Woodruff.

**STATEMENT OF REV. C. ROY WOODRUFF, PH.D., EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF PASTORAL COUNSELORS**

Rev. WOODRUFF. Mr. Chairman, my name is Roy Woodruff. I am executive director of the American Association of Pastoral Counselors, AAPC, and I very much appreciate this opportunity to testify on behalf of our organization.

Pastoral counselors are ministers, priests, and rabbis or other persons endorsed by religious faith groups who have received specialized graduate training in both religion and the behavioral sciences, as well as extensive clinical training, making them among the best trained mental health professionals.

As an interfaith organization, our association represents over 3,200 pastoral counselors and more than 100 pastoral counseling centers that are accredited in the United States. AAPC certified and affiliated pastoral counselors have access to faith group congregations numbering over 20 million people, with outreach to millions more.

We provide more than 3 million hours of treatment annually, covering a wide array of disorders.

The American Association of Pastoral Counselors takes the position that, as a matter of social moral responsibility, every American, without exception, must have access to quality health care and that mental and emotional illness must be covered in benefit packages on the same basis and to the same extent as physical illness.

We fully support H. Con. Res. 52, sponsored by Rep. Mike Kopetski of Oregon, and S. Con. Res. 16, sponsored by Senator Richard Shelby of Alabama, expressing the sense of Congress that any legislation enacted to reform the health care delivery system of the United States should insure that every person has access to necessary treatments for mental disorders that are comparable and equitable to the access provided for treatments for physical illnesses, and should include a continuum of mental health services to assure appropriate and effective treatment for mental and emotional illness.

The availability of a full range of mental health services without arbitrary limits, together with the nondiscriminatory assessment of coinsurance and deductibles, will assure a cost-effective system that obviates the use of inappropriate and more costly treatment. For example, a severely limited outpatient mental health benefit often results in shifting service to what may be unnecessary, but covered inpatient treatment.

We also believe that a health care system that works will depend in large part on the consumer's continued prerogative to choose the provider of his or her choice, whether it be in an agency or private practice setting.

In regard to the often overlooked faith issues in mental health care and treatment, a 1992 Gallup Poll showed that 66 percent preferred a professional counselor or therapist who represented spiritual values and beliefs, and 81 percent preferred to have their own

values and beliefs integrated into the counseling psychotherapeutic process. AAPC-certified pastoral counselors are trained and qualified to meet this need and provide a service which needs to be included in benefits packages.

Treatment through a pastoral counseling center also often mitigates the stigma that can be associated with mental health treatment provided through other settings.

Moreover, the cost for pastoral counseling services are among the lowest in the delivery of mental health services, while the standards of practice are among the highest.

To conclude the oral portion of my testimony, I would like to quote the words of a distinguished member of this subcommittee, a psychiatrist as well as a legislator, Rep. Jim McDermott: "The chance to help patients by prescribing drugs," he said, "represents a major advance in the treatment of mental illness, but is no substitute for the caring and concern every doctor should show for every patient, or for the nonmedical services patients often need in order to achieve real health."

We believe that the achievement of real health is a worthy goal for national health care reform.

Thank you very much for this opportunity, Mr. Chairman.

[The prepared statement follows:]

## Testimony Submitted

By

C. Roy Woodruff, Ph.D.

Executive Director

American Association of Pastoral Counselors

### THE ROLE OF PASTORAL COUNSELING

Religious communities are major gateways for those seeking relief from human suffering and from the mental and emotional illness which is often its byproduct. Millions of Americans attend their places of worship on a regular basis and millions more attend infrequently.<sup>1</sup> In addition, there are those who suddenly and desperately turn to a religious institution as a possible solution to their problems --the everyday problems that beset today's society: alcoholism and drug abuse, child and spousal abuse, family and societal violence, suicide, homelessness, AIDS, alienation, family conflict, depression, and anxiety.

Religious communities have traditionally sought to provide spiritually-based solutions for those in trouble. Clergy have listened intently to personal problems for centuries, and have cultivated a spiritual counseling response to those suffering from mental and emotional disorders. This spiritual counseling, an important ministry of the faith community, has given rise to a recognized and certified discipline in the mental health field which integrates theology with the behavioral sciences. This discipline is known as Pastoral Counseling or pastoral psychotherapy.

Many who seek help from ministers, priests, and rabbis are suffering from mental and emotional illness. Traditional spiritual counseling continues to help many of these people. It was recognized long ago, however, that in many cases specialized professional care was necessary for effective treatment.

Though psychotropic drugs have provided significant advances in the treatment of serious mental illness, a wide range of mental and emotional disorders require psychotherapy. U.S. Representative Jim McDermott (D-WA), a member of the House Ways and Means Committee and a psychiatrist by profession, stated, "The chance to help patients by prescribing drugs represents a major advance in the treatment of mental illness, but it is no substitute for the caring and concern every doctor should show for every patient, or for the non-medical services patients often need in order to achieve real health." For many, pastoral psychotherapy is the treatment of choice.

In the 1920's, The Reverend Anton Boisen, Father of the Clinical Pastoral Education movement, revived the important role of clergy in the treatment of mental illness by placing theological students in supervised contact with patients in mental hospitals. This innovative educational program brought disciplined training to the historical linkage between faith and mental health.

The integration of religion and psychology for psychotherapeutic purposes began in the 1930's with the collaboration of Norman Vincent Peale, a renowned minister, and Smiley Blanton, a psychiatrist, to form the American Foundation of Religion and Psychiatry, now the Institutes of Religion and Health.

The role of pastoral counseling has, therefore, evolved through the years from religious or spiritual counseling to pastoral psychotherapy which integrates theology and the behavioral sciences. Pastoral counseling has now become a major provider of mental health services in this country, accounting for over 3 million hours of treatment annually in both institutional and private settings, offering individual, group, marital, and family therapy.

AAPC was founded in 1963 as an organization which certifies Pastoral Counselors, accredits pastoral counseling centers, and approves training programs. It is an interfaith organization representing in pastoral counseling work more than 80 faith groups including the Protestant, Catholic, and Jewish faiths. It is non-sectarian and respects the spiritual commitments and religious traditions of those who seek assistance without imposing counselor beliefs onto the client.

Pastoral psychotherapists work with the classified mental and emotional disorders and utilize a variety of forms of psychotherapy with the disciplined integration of relevant theological and spiritual perspectives. Pastoral Counselors either practice through pastoral counseling centers, hospitals, clinics, prisons, universities, religious settings, or are in private practice. In whatever setting, they draw faith and strength from their participation in the faith group and congregation with which they are affiliated.

The ethics and standards of AAPC require that Pastoral Counselors work in conjunction with others and not in isolation. The AAPC requires that they hold a continuing responsible relationship in their local religious communities. Pastoral Counselors receive ongoing supervision and consultation in order to provide optimum treatment as well as protection to the counselees, and they engage in a peer review process to ensure the utilization of the best possible care for patients. At the same time Pastoral counselors are an intrinsic part of the mental health delivery system, collaborating with the other mental health disciplines and employing the latest and most effective psychological techniques combined with the spiritual dimension. When medication is deemed necessary, the Pastoral Counselor refers the client to a psychiatrist for necessary evaluation. In short, Pastoral Counselors provide clinically accountable and spiritually sensitive care to those who seek their assistance.



AAPC in recent years has become a partner in the larger mental health community as well, joining with such organizations as the National Mental Health Association, the American Psychological Association, the American Association for Marriage and Family Therapy, the American Psychiatric Association, and the National Association of Social Workers to work on behalf of the mentally ill. AAPC has also begun to work with federal mental health agencies such as the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health, to link pastoral counseling even closer to the core mental health disciplines. AAPC has become a member of the Interreligious Health Care Access Campaign, a national interfaith group for health issues. It is also represented in the National Quality Caregivers Coalition, sponsored by the Rosalynn Carter Institute, and the Rosalynn Carter Symposium on Mental Health Policy. In addition, AAPC functions as a principal organization in the Congress on Ministry in Specialized Settings (COMISS), an interfaith coalition of 15 of the various professional, ecclesiastical, and provider groups in the fields of pastoral care, counseling, and education.

<sup>1</sup> A recent poll showed that 90 percent of Americans consider themselves to be religiously oriented.

#### THE EFFICACY OF PASTORAL COUNSELING

Pastoral Counselors have treatment success rates comparable to those of the highest quality of mental health services. A study underwritten by The Samaritan Centers, a network of pastoral counseling centers, indicated that 80 percent of their clients reported having been helped. Pastoral counseling, offering a modality of treatment which maintains the natural connection between the physical, mental, and spiritual dimensions, believes that this connection fosters a sound and lasting foundation for mental health treatment of the whole person.

In this awareness of the spiritual dimension in human wholeness, Pastoral Counselors stand in good company. One of Carl Jung's chief contributions as a psychoanalyst and writer was to bring spirituality into psychology. Another influential writer, Abraham Maslow, brought spiritual aspects to therapy. William James, America's most influential early psychologist, studied religious experience as an expression of levels of growth. Psychiatrist Karl

Menninger was a pioneer in the integration of the psychological and the theological disciplines because he believed in the "inseparable nature of psychological and spiritual health." M. Scott Peck, best selling author and psychiatrist, effectively expresses that belief in our own day.

Famed editor, Norman Cousins, stated, "Over the years, medical science has identified the primary systems of the body -- circulatory system, digestive system, endocrine system, autonomic nervous system, parasympathetic nervous system, and the immune system. But two other systems that are central to the proper functioning of a human being need to be emphasized: the healing system and the belief system. The two work together. The healing system is the way the body mobilizes all its resources to combat disease. The belief system is often the activator of the healing."

A Gallup Poll conducted in February 1992 determined that 66 percent of those surveyed prefer a counselor who represents spiritual values and beliefs, and that 81 percent prefer to have their own values and beliefs integrated into the counseling process. Pastoral counseling is particularly responsive to these people in integrating the spiritual and psychological dimensions of human experience and attending to the values and beliefs of the client.

Studies suggest that many mental health professionals in other disciplines are beginning to develop the religious dimensions in their own work. They are recognizing as never before the power of spiritual commitment creatively used in the healing process. The ever-growing interaction and collaboration between Pastoral Counselors and the larger mental health field is helping to bring this about. Richard Simon, Ph.D., editor of the *Family Therapy Networker*, stated in a recent article that "the rigid divorce between spirituality and psychotherapy may no longer be necessary, that the two are more compatible than we once thought."

Pastoral counseling has matured rapidly as a behavioral discipline and continues to gain increasing acceptance as a core mental health discipline.

Practitioners in the field are constantly evolving therapeutic theory and methods to enable the discipline to advance further and effect higher rates of success outcomes.

"It only makes sense that religion and psychology -- each of which is concerned with the fullness of the human experience -- should be recognized as partners, because they function as partners within the human psyche." (Dr. Arthur Caliendo, Senior Minister, Marble Collegiate Church, New York City)

## THE EDUCATION OF PASTORAL COUNSELORS

A certified Pastoral Counselor is an ordained clergy person or endorsed religious person who has received specialized training in religion and the behavioral sciences, and who is certified by the American Association of Pastoral Counselors (AAPC). In addition, the Pastoral Counselor may be state licensed as a professional counselor or in a number of mental health specialties, such as marriage and family therapy, clinical psychology, or social work.

By studying theology as well as psychology, Pastoral Counselors are trained in two disciplines instead of one, providing a unique opportunity to integrate them both into an effective psychotherapeutic process. As a result of this dual training, Pastoral Counselors are among the most educated and competent of mental health professionals.

Candidates seeking certification by AAPC are thoroughly tested and evaluated to assure that AAPC certifies only the most competent individuals who have extensive education and clinical training and who possess the highest morals and personal standards. Following certification by AAPC, the Pastoral Counselor must submit an annual self-report form which verifies continued adherence to the standards of practice set forth by the Association, including their continued good standing within their faith groups.

In its certification role, the AAPC has as its purposes the following: "professional excellence of pastoral counselors; exploration, clarification and guidance of human life, both individual and corporate, at experiential and behavioral levels through a theological perspective; relations with ecclesiastical groups; inter-professional relationships; and increased understanding of the ministry of pastoral counseling." (AAPC Constitution)

Typical education and training for the Fellow level Pastoral Counselor consists of a Bachelor's degree from a college or university, a 3 year professional degree from a seminary (e.g., M.Div., or B.D.), and a specialized masters or doctoral degree in the field, (e.g., M.A., S.T.M., Th.M., S.T.D., or D.Min. (clinical degrees)), and Ph.D. or Th.D. (teaching/clinical degrees). A significant portion of this education is spent in some clinical training setting. Many university schools of theology, graduate institutes, and seminaries around the country prepare ministers for pastoral counseling.

The standards set by AAPC require intensive studies in the behavioral sciences and numerous hours of clinical training and supervision. Among the clinical areas considered important by AAPC to achieve educational objectives for pastoral counseling are: Psychopathology, Group Dynamics, Theories of Personality and Personality development, Theories of Counseling and Psychotherapy, Research Methods in the Behavioral Sciences and Theology, Interpersonal Relations, and Marriage and Family Dynamics. This clinical training involves the completion of at least 1,625 hours of supervised clinical experience and 250 hours of direct approved supervision of one's work in both crisis and long-term situations.

While some mental health core disciplines require their professionals to obtain only one review for certification, and thereafter to adhere to the standards set by their discipline, AAPC certified Pastoral Counselors must be reviewed each time they seek a higher level of membership in AAPC.

The basic level of AAPC membership is the Member level which is seen as a temporary step on the way to the Fellow level. Those at the Member level must remain under the supervision of those professionals of their discipline who have a greater degree of experience and expertise in pastoral counseling than they do. At the Fellow level, the counselor receives recognition of competence to work without constant direct supervision. The highest level of membership in the AAPC is that of Diplomate, which qualifies one to teach and supervise Pastoral Counselors, pastoral counselors-in-training, and clergy in their pastoral care ministries.

In addition to setting standards for the certification of individual Pastoral Counselors, AAPC also sets standards and offers accreditation for pastoral counseling centers. This includes the approval of training programs in pastoral counseling. Periodic reviews are made of all accredited centers and approved training programs to assure maintenance of the high competence required by the standards.

## THE COST-EFFECTIVENESS OF PASTORAL COUNSELING

Pastoral Counseling is one of the most cost-effective modalities of treatment in the field of mental health.

It is the prevailing ethic of Pastoral Counselors that every effort is made to make mental health services available to those who seek them. This has been and continues to be a common practice despite the rapidly escalating costs of providing service. Sliding scales for patients soften an often otherwise undue hardship for receiving therapy. Nevertheless, as demand grows for mental health services by Pastoral Counselors, and as third-party payments grow increasingly less available, the pressure mounts to find solutions that will not leave poorer patients and the uninsured without needed quality service.

To illustrate the cost-effectiveness, the nationwide average fee collected per 50-minute

session is just under \$50 for certified Pastoral Counselors. A number of factors have enabled Pastoral Counselors and pastoral counseling centers to provide quality service at a lower cost than other mental health disciplines and to be among the most cost-effective providers of quality mental health services. One factor is the willingness of Pastoral Counselors to work for relatively modest salaries. Also, the ability of pastoral counseling centers to function cost-effectively relates to their not-for-profit orientation and to the funding efforts by boards of directors, church and synagogue contributions, and decreased overhead costs when working in partnership with congregations.

A few insurance companies have authorized reimbursements for pastoral counseling and some pastoral counseling centers have reimbursement relationships with managed care organizations, employee assistance programs, and self-insured corporations/organizations. However, there is still insufficient insurance coverage and managed care availability, both for mental disorders in general and for care by qualified Pastoral Counselors. This insufficiency is in part, due to lack of knowledge, misperception, and confusion about mental illness and pastoral counseling. Pastoral counseling should not be denied to patients who wish to avail themselves of this modality of treatment because of lack of recognition by third-party payers.

#### THE PRINCIPLE OF CONSUMER CHOICE

The right of consumers to select providers of their choice in any health care delivery system, and in any system of national health insurance, is a universally articulated desire.

National organizations interested in health care reform have included this principle almost without exception. For example, the American Association of Retired Persons (AARP), one of the most powerful advocacy groups in the country, has stated, "All individuals should have a reasonable choice of health care providers. Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions."

The National Mental Health Leadership Forum, an umbrella group composed of the major national mental health organizations, has also endorsed the principle of consumer choice as one of the foundations of health care reform. It stated that, "A consumer-sensitive health care system will provide for consumer participation in treatment planning decisions, including service selection, service provider, service timing, and service setting. It should also ensure a range of service settings as part of an integrated delivery system, and should ensure that services are delivered in the least restrictive environment practicable."

The coming of age of pastoral counseling has been marked through its recognition by other core mental health professions and the growing demand for pastoral counseling services by mental health consumers.

The ability of consumers to choose pastoral counseling for mental health services would impact cost-containment in a positive way because of the relatively low costs and high accountability of pastoral counseling. (Rf. The Cost-Effectiveness of Pastoral Counseling)

The demand for a pastoral oriented therapy modality is well-documented by the Gallup Poll (1992) in which 1,000 persons (50 percent male and 50 percent female) were surveyed. Sixty-six percent preferred a professional counselor who represented spiritual values and beliefs, and 81 percent preferred to have their own values and beliefs integrated into the counseling process.

This poll revealed a broad base of consumers who value the kind of mental health services which qualified Pastoral Counselors offer. That expressed preference cut across all demographic categories; sex, age, region, education level, and race.

#### PASTORAL COUNSELING AND PREVENTIVE CARE

Pastoral counseling goes hand-in-hand with preventive mental health care. From the perspective of community prevention, easy access to pastoral counseling centers, through referrals from places of worship and other community and professional referral sources, provides the person with early intervention before the illness or the problem becomes chronic and/or resistant to treatment.

Treatment through a pastoral counseling center or a private practice Pastoral Counselor also mitigates the stigma often associated with the treatment of mental and emotional illness provided through a traditional psychiatric hospital or medical hospital. Persons have already acquired a level of comfort with their religious setting and, therefore, are less resistant to entering a pastoral counseling center. This setting, consequently, often provides a more acceptable and more therapeutic atmosphere that helps to bring a person into communion with one's true identity.

Places of worship are community gateways through which millions of persons pass each week. Many of their problems and illnesses can be referred through the clergy to pastoral psychotherapists quickly, sometimes preventing individual and family tragedy before it



strikes. Mental health education workshops are offered by Pastoral Counselors through church and synagogue settings. Many pastoral counseling centers also perform developmental and mental health screening to avoid and ameliorate illness. Pastoral Counselors also work in collaborative relationships with other mental health professionals in designating treatment plans that optimize care and follow-up for patients who require other levels of treatment or specialization.

Pastoral Counselors provide preventive services in the hospital setting, in industrial and corporate settings, prisons, universities, the military, and primary and secondary schools, as well as in church and synagogue settings. In general, the entire community becomes a service arena for detection and prevention. Pastoral Counselors are in a position to provide crisis-oriented assessments in early diagnoses of many debilitating personal states, and to effect appropriate outpatient treatment of these and other conditions.

Other forms of preventive mental health services by Pastoral Counselors are counselor education for community clergy and others who are able to share this education in their communication with individuals, families, congregations, and the broader community. In addition, they participate in the development of a host of community mental health services such as half-way houses, hospices, and the like.

Because certified Pastoral Counselors bring a mature, wholistic, and experienced presence to the public need for preventive services, their participation in these types of preventive activities helps to ease the enormous pressure on the mental health care delivery system and thereby *saves taxpayer dollars*.

Mr. LEVIN. Thank you.

The Chairman asked if I might ask his questions, so let me do that quickly.

The first one relates to the definition of the benefit package, present and future, whether you would prefer it be done by a board or congressionally. Let's just go down the line. Do you want to say, each of you, what you prefer?

Mr. JONES. The National Mental Health Association prefers that Congress set the benefits. We do not have a position on HIPC's, and having listened to the Chairman, we are undecided on that.

Mr. LEVIN. That is the second question about whether you would want the benefits managed strictly through a HIPC mechanism or beyond.

Mr. JONES. We support organized systems of care, but have not decided whether to endorse the HIPC's. I think we are more interested in a wider range of alternatives.

Mr. LEVIN. Mr. Bowers.

Mr. BOWERS. Consistent with the other panelists, we would prefer Congress to establish a benefit level. We would also want to make sure, regardless of when that board is created, that there be balanced representation, so that attention to those who need mental health services could be included.

Regarding the health insurance purchasing cooperative, I think we have taken no position. Our association has not polled its members at all on that, so we would have to pass until we got a little more detailed picture of what that looked like.

Mr. LEVIN. Mr. Trachtenberg.

Mr. TRACHTENBERG. Our membership has not really taken a position on the first question, but as a rule we believe it is important to be able to hold someone accountable for decisions, and I think we would find it easier to hold the Congress accountable than an individual board, so I think we would opt probably for the Congress.

With respect to the second question, we favor a market-driven system. If HIPC's or other kinds of purchasing co-ops meet that requirement for getting the best price for health care and mental health care, then we would support that.

Mr. LEVIN. Mr. Diehl.

Mr. DIEHL. Congressman, our organization has not taken a formal position on either question. Personally, I would just prefer, from the position of running an organization that provides treatment, that I would prefer holding the Congress accountable for the decision and the inclusion of a comprehensive benefit in health care reform, but no opinion on the HIPC yet.

Mr. LEVIN. Rev. Woodruff.

Rev. WOODRUFF. I think we would prefer that Congress be the one to set the benefits package. On the second question, we have no really clearly polled position in our organization about that. We are part of the interreligious health care access campaign that has come out in favor of a publicly financed system.

Mr. LEVIN. Let me just ask one last question and then we will go on to the last panel. Mr. Trachtenberg, in terms of your model, let's assume that it is figured out about what mental health costs are today, more or less, and let's say we go over to a market ap-

proach in terms of mental health. Let's say it is 10, 12, 14 percent, we allocate a certain amount that we would hope might cover mental health services on an expanded basis in this country. How are we sure that the program operates within some kind of a notion as to cost?

Mr. TRACHTENBERG. Well, I think there are a couple of things. First of all, we have done a fair amount of study right now, as has NIMH, on what the costs of mental health care is as a percentage of the total health care budget, and it looks like it is somewhere between 9 and 14 percent, depending on the eligible population and the services covered. So it is pretty much close in terms of the numbers.

We are not suggesting that that amount of money be set aside and that it is irrevocable. What we are suggesting is that we set that as a target in terms of a premium limit, and that if you go into some kind of a competitive system or accountable health plans or something of that nature, that the various providers, whether they are mental health providers or large organized systems of care, would then compete for the business of delivering mental health services. A HIPC or other purchasing group would then take a look at the various proposals for providing mental health services, and if a particular provider or group of providers come in and say that they are going to provide 3 percent of the total health care dollar for mental health, and all the data shows that the right amount is somewhere between 9 and 11 percent, I think the community then should be in a position to question that particular set of providers in terms of what they are going to provide for that kind of money.

There was a study in 1985 that showed that for the 400-some HMOs that they studied, these organizations allocated 3 percent for mental health care as a percentage of the total health care dollars spent, and that is simply not enough.

Mr. LEVIN. But to say the standard benefit package has some standards for the kind of mental health care that must be provided, that is what we are talking about, but how do we know, if there isn't some outer limits, how do we know that mental health services are being provided on a cost-effective basis? What would happen, if we had a standard minimum package based on a certain assumption as to what mental health costs are today, some rough approximation of the proportion?

So we assume they were going to cost \$50 billion, say \$75 billion. Now, what happens if it appears half-way through a year or after a year that they are going to cost \$100 billion? What do we do then?

Mr. TRACHTENBERG. Let me respond in this way. We are suggesting some kind of at-risk arrangement, so that you capitate the amount of money or some other kind of risk program. You would also apply consumer responsibility for some kind of copay where that is appropriate. You would put the accountability and the bulk of the burden on the organized system of care, the integrated psychiatric services networks to come within the capitated amount for the services covered under the plan. We may have to build into the system some reinsurance mechanism or something of that nature for the others, but the integrated psychiatric services networks



would have a legal obligation at the same time to make sure that you have an adequate system, that you don't have undertreatment.

What we proposed are very stringent Federal qualifications for participating integrated psychiatric services networks, such as diagnostic and referral centers that would be open 24 hours a day to conduct evaluations, assessments, diagnosis, and referral to the appropriate level of care.

So I think between the capitation or other kind of at-risk activity, the consumer cost-sharing requirements, and the stringent Federal qualifications, I think you can put together a responsible system that provides medically necessary care, and hopefully will avoid undertreatment.

Mr. LEVIN. So you have full confidence that there will be adequate treatment, if you set standards and you have various units bid for who will carry out the mental health services?

Mr. TRACHTENBERG. I think if you do not have arbitrary restrictions, and you have the full continuum of care available, including inpatient, to supervised living, to partial hospitalization, to residential levels, to intensive outpatient, to home care—if you have that full armamentarium of services available for the patient—you can effectively treat that patient, as many of our members are now doing under capitated payments.

Mr. LEVIN. I think the more information you supply on this, the better. I think there will be some skepticism that there won't be a premium on undercare to make the bid a winner, instead of a loser. There is some experience outside of the psychiatric field which questions whether, even if you can have the competitive model in place, that there isn't too much a premium on meeting the ledger sheet, instead of the needs of the patient.

You want a parity, so I won't make psychiatric care or mental health care more sensitive than other kinds of care, but I think clearly there are sensitivities, and if cost drives treatment, if the balance sheet drives treatment, you pay potentially a high risk.

The time is late and this is just the beginning, surely not the end of the discussion. Many thanks.

I think my colleague, Mr. Kleczka, is going to channel the session of the next panel.

Mr. KLECZKA [presiding]. Let me welcome our final panel of this elongated hearing. We started early this morning and, for whatever reason, the dental folks are last. They have to check with Chairman Stark and see why you folks are last on the agenda.

I did have the opportunity to meet with some of the dental folks prior to coming to the hearing a few short minutes ago and, looking over your testimony versus what they told me, there seems to be some disparity. The folks that visited me indicated they want no part of any basic plan, "leave us alone, we like it the way things are."

I am not going to give you their names, because they are friends of mine, but I think the American Dental Association should start speaking out of one hymn book. Nevertheless, let's start off with our witness, Dr. Zapp, representing the American Dental Association.

**STATEMENT OF JOHN ZAPP, D.D.S., EXECUTIVE DIRECTOR,  
AMERICAN DENTAL ASSOCIATION**

Dr. ZAPP. Thank you, Mr. Chairman and members of the subcommittee. I will be sensitive to the hymn book and what I paraphrase. I am also sensitive to the fact that the subcommittee has been at this all day and we were requested earlier by the Chairman to try to summarize our oral statements, and I will do that and ask permission to—

Mr. KLECZKA. Did he indicate why you were last on the panels?

Dr. ZAPP. It is alphabetical.

If we could have permission to submit a factsheet and, as an attachment to our statement, a brochure that I was going to discuss in a minute.

Mr. KLECZKA. Without objection.

Dr. ZAPP. I am John Zapp. I am the executive director of the American Dental Association, with 140,000 members. On behalf of the association, I am pleased to present a brief summary of our testimony for the afternoon.

I think one thing that all of us would agree on the panel and the dentists who were in to see you this afternoon, Mr. Chairman, is that certainly in the forefront of dentistry is prevention, and we probably have one of the best success stories to tell of any of the health care delivery components of the country at this point in time.

Dentistry, as a result of the efforts and the incidence of dental disease, which is decreasing in the United States, I would like to quote some figures from the NIDR which showed, as a direct result of fluoridation, that half of today's school children have never experienced a dental decay, compared with only 36 percent in 1980, and as recent as 1970, when there was only 28 percent of the students that were in the same situation. So I think we all feel very comfortable and very proud of the prevention aspects of our profession.

Education—clearly, there are barriers other than financial that stand in the way of proper treatment and good oral health. We have seen low-utilization of dental benefits at approximately 28 percent in parts of the population where there were no financial barriers, such as in the Medicaid program, and this has got to be a team, community and school education program to get these people to make use of the opportunities that are already financially available to them. Of course, we would like to see an expansion for the low and no-income individuals as relates to comprehensive dental care.

As it relates to the public sector's involvement in payment for dental services, I think we also have an outstanding story to tell and one that should be welcome particularly to this committee that has the responsibility for finding finances for any type of new program, and that is that currently only 4 percent of the dental care in this country is paid for by public funds, and that is a combination of Federal, State, and local.

The balance of it, and one of the things that we are mostly concerned about, is being paid for either by dental benefits plans that are currently in existence, somewhere between 43 and 45 percent of the dentistry that is delivered today, and the balance is private pays.

Of course, we are very concerned about a change in the tax structure that would provide a disincentive to this growing amount of private sector delivery that is currently occurring, and I think perhaps the dentists that were in meeting with you today were exhibiting their concern on that, that there could be a disruption in the current delivery system as it relates to the private sector financing, either through private pay or through labor-management negotiation.

I think that the provision of preventive care to children is also one of the things that has been a hallmark of the profession, that we would encourage fluoridation and sealants. These are things that we have all been a part of, and increasing prevention is a good news story as far as we are concerned, and I would hope that for the committee's record the material I would like to submit on any disruption that may occur as a result of proposed changes in the tax structure of deductibility for dental benefit plans would be something that we could come back and meet with the committee or the committee staff on at a later time, because clearly that is one of our major concerns.

I would like to thank the committee for the opportunity to appear before them this afternoon.

Thank you.

[The prepared statement and attachment follow:]



American  
Dental  
Association



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**STATEMENT OF THE  
AMERICAN DENTAL ASSOCIATION  
TO THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ON  
HEALTH CARE REFORM  
PRESENTED BY  
DR. JOHN ZAPP**

**MARCH 30, 1993**

Mr. Chairman and Members of the Subcommittee:

My name is Dr. John Zapp. I am the Executive Director of the American Dental Association. On behalf of the Association's 140,000 members, I wish to present a brief summary of our views on health care reform.

After an extensive evaluation of the current dental care system in the United States, and several different types of delivery systems in other countries in the world, the American Dental Association has developed a strategy that will refine our system to greatly enhance the oral health of the American people at a minimal public cost.

The key concepts that underlie our approach to health care reform have been developed to expand upon those aspects of our dental care system that have been successful and cost efficient, and to add to our system features that will remove any remaining barriers to seeking appropriate and timely dental care.

Our recommendations strongly stress:

**PREVENTION**

Dentistry has an impressive and effective record of advocating the prevention of dental disease. As a result of our efforts, the incidence of dental disease is decreasing in the United States, as evidenced by recent epidemiological studies. Still, however, the incidence of dental disease remains too high in identifiable segments of the public.

Prevention of disease is relatively inexpensive, is effective in dentistry, and requires a minimum of patient effort. The small investment of public funds in community water fluoridation, for example, has paid tremendous dividends financially and in citizen well-being.

**EDUCATION**

There are barriers other than financial that stand in the way of some of our citizens in seeking timely dental care. We have seen a low utilization of dental benefits, about 28%, in the population that have had all financial barriers to seeking dental care removed under the Title XIX (medicaid) program. Only about 55% of persons with a private dental benefits program use it in any one year. The value of seeking timely dental care, including preventive care, can be instilled in our people through enhanced education. We need to be innovative in converting the public's observed needs for dental care to their demand for dental care.

### ENCOURAGEMENT OF THE PRIVATE SECTOR

Currently in the United States, only 4% of the money spent for dental care is public money, the rest comes from the private sector. Private sector dental benefits plans directly provide about 45% of the funds spent for dental care. Indirectly, private plans account for even more money currently spent because of patient participation in the costs of treatment, the co-payments, when the majority of the costs are plan benefits. The unique design of dental benefits plans has resulted in stability and moderation in the escalation of dental care costs, through patient cost-sharing and enhanced provider competition. Encouragement of expansion of the private dental benefits market would capitalize on these advantages and not require a transfer of the \$36 billion spent annually for dental care in the private sector to the public sector.

### EXTENSION OF BENEFITS TO ALL INDIGENTS

Currently, only children in indigent families are required by federal mandate to have comprehensive dental care provided to them. We believe that all indigent individuals, as defined by the federal poverty index, regardless of age, should have access to comprehensive dental care. We also recommend that the current medicaid program be privatized for increased efficiency of administration.

At this time, we are unable to comment on the composition of any "core benefits" package because we have not seen any proposals for such a benefits structure. We do advocate, however, that basic dental preventive services for children should be included in any plan that is developed. It will be critical in our analysis of any proposal that comes forward to evaluate the potential disruptions that would occur under those proposals in our current system that serves the 67% of our population that is now receiving regular dental care. Some of our particular concerns are:

- 1) inappropriate application of patient cost-sharing provisions to entry-level and preventive services may reduce timely access to dental care
- 2) taxation of health benefits, either directly or by removal of current tax exemptions, will greatly harm private dental benefits plans, as individuals will use their tax-free benefits to protect their hospital-medical-surgical insurance plans and elect not to maintain their dental benefits plans. In addition, employers will be reluctant to continue to provide dental benefits plans when the costs for these plans are not considered a business expense. When faced with the prospect of paying an increased amount of money towards their health insurance costs, employees, especially during these difficult economic times, will elect to forego their dental benefits plan and take the money formerly allocated to their dental plan as increased wages.
- 3) limitation on the freedom of patients to choose the dentist from whom they will receive dental care will result in the disruption of excellent and long-standing doctor/patient relationships.

It is important to note the important differences between dental diseases and dental care delivery, and general disease and medical care delivery in designing any health care reform. It is critical that any modifications of our dental care system specifically address problems with the dental care system, with solutions that will solve those problems.

The American Dental Association would like to be of assistance to you as you consider any reform of our dental care system.

In conclusion, let me emphasize our recommendation that any reforms that are contemplated build upon the tremendous success of our current dental care system; that we build upon that system in a way such that nothing is done to jeopardize the current excellent dental care that a large majority of Americans receive. The American Dental Association stands ready to assist you in this effort.

Mr. Chairman, this concludes our testimony. Thank you for the opportunity to present our recommendations. We ask that this statement be included in its entirety in the official record of this hearing.



**AMERICAN DENTAL ASSOCIATION  
INFORMATION ON DENTAL HEALTH AND DENTAL CARE**

**PROFESSIONAL PROFILE**

- \*\* 1992 ADA Membership: 139,626
- Total Dentists: 190,842
- General Practitioners: 154,713 or 81% of all dentists
- Specialists in U.S. 36,129 or 19% of all dentists
- (Source: ADA Division of Membership and Marketing Services, 1993)

**PREVENTION OF DENTAL DISEASE**

- \*\* \$100 billion in dental costs saved during the 1980's because of emphasis on preventive oral health measures; \$39 billion of this was due to advancements in dental research. (National Institute of Dental Research, 1992)
- \*\* as a direct result of water fluoridation, 50% of today's school children are free of tooth decay, compared to 36.6% in 1980 and 28% in the early 70's. (National Institute of Dental Research, 1988)
- \*\* it has been estimated that, for each dollar spent on preventive services, five dollars are saved on therapeutic services (no citation)

**ACCESS TO DENTAL CARE FOR CHILDREN AND ADULTS**

- \*\* individuals seeing a dentist last year--57%  
....in the last two years--67%  
(National Center for Health Statistics, Vital and Health Statistics, Dental Services and Oral Health: United States, 1992)
- \*\* number of individuals seeing a dentist within a year:  
with dental insurance--71.1%  
without dental insurance--53.1%  
(ibid., 1989)
- \*\* of 26.7 million Medicaid eligibles, only 4.4 million (17%) visited a dentist. (American Dental Association, Survey of State Programs in Medicaid, 1992)
- \*\* 125 million of 245 million Americans have private or public dental insurance. (U.S. Department of Health and Human Services, National Center for Health Statistics, Vital and Health Statistics, Dental Services and Oral Health: United States, 1992)

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- \*\* over 100 million Americans (about 50%) live in communities which do not have fluoridated water. (Allukian, M., "The Neglected American Epidemic", The Nation's Health, May-June, 1990.)
- \*\* 20% of our children have 65% of the dental disease in children. (ibid.)
- \*\* black, low-income and native American children, respectively, have 65%, 91% and 265% more untreated tooth decay than their peers. (Gift and Corbin, 1989; Dillenberg, 1988; Rhodes, et al, 1987)
- \*\* although about 100 million Americans have some form of private dental insurance, 140 million individuals visited the dentist in 1991. (National Center for Health Statistics, Current Estimates from the National Health Survey, Series 10)

#### COST OF DENTAL CARE

- \*\* Dental Expenditures for 1991;

Direct payment by patients:	19.9 billion (53%)
Payment by benefit plans:	16.1 billion (43%)
Government (federal/state/local):	1.1 billion ( 4%)
Total Expenditures:	37.1 billion

(Source: U.S. Department of Health and Human Services, HHS News, January 29, 1993.)

- \*\* Projected Annual Growth of Health Care Expenditures 1991 to 2000;

Total Health Care Expenditures:	9.1%
Hospital:	9.7%
Physician services:	10.4%
Nursing home care:	9.2%
Dental care:	6.4%

(Source: HCFA, "Projection of National Health Expenditures through the Year 2000," Health Care Financing Review, Fall 1991, Volume 13, No. 1.)

- \*\* per capita growth of expenditures for dental care, adjusted for inflation, has risen about 1% annually, from 1979-1989; suggests that prevention of dental disease has allowed dental expenditures to grow at a reasonable rate. (U.S. Department of Health and Human Services, HHS News, January 29, 1993)

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- \*\* dental costs as a per cent of health care costs;  
1970--6.3% ; 1991--4.9%
- dental costs as a per cent of the Gross Domestic Product;  
1970--0.5% (all health care 7.4%)  
1991--0.7% (all health care 13.2%)

#### ADDITIONAL INFORMATION

- \*\* barriers to access to care are multiple--financial, personal, cultural, educational, language, geographic, . etc.; all must be addressed to improve access. Removing only financial barriers does not insure improved access to care, as evidenced by the 17% utilization of dental benefits by Medicaid eligibles who have no financial barriers to seeking care.
- \*\* solution to improved oral health is prevention, adequate and timely treatment, adequate financial support for programs to treat the indigent, and dental health education to remove other barriers to care.



Mr. KLECZKA. Thank you, Dr. Zapp. Your documents will be made a part of the official record.

We will now hear from Jane Kendall, representing the American Dental Hygienists's Association.

**STATEMENT OF JANE L. KENDALL, R.D.H., C.A.E., DIRECTOR OF GOVERNMENTAL AFFAIRS, AMERICAN DENTAL HYGIENISTS' ASSOCIATION**

Ms. KENDALL. Thank you. Good afternoon.

I am Jane Kendall. I am director of governmental affairs for the American Dental Hygienists' Association, and I am a licensed dental hygienist. I thank the subcommittee for this opportunity to testify regarding preventive services, particularly in the context of health care reform.

I am pleased to summarize ADHA's recommendations. We are going to submit them in greater detail for the record prior to the close of the record.

ADHA is the largest national organization representing the professional dental hygienists across the country, and dental hygienists are the primary providers of preventive oral health services.

ADHA is pleased that the reform of the Nation's health care delivery system is one of Congress' highest domestic priorities, and we are committed to participating in the process.

ADHA strongly advocates universal access to cost-effective quality health care which, at a minimum, includes preventive oral health services. Oral health is part of total health.

Investing in America's oral health care will translate directly into fiscal savings. It is a known fact that preventive care can reduce the need for expensive critical care.

Last July, the National Institute of Dental Research reported that Americans saved nearly \$100 billion in dental dollars during the 1980s, because of improvements in oral health. Remarkably, all economic factors, such as population growth, increases in numbers of dentists and increases in numbers of Americans with dental insurance, might have significantly increased the growth of dental expenditures over the past decade.

The U.S. Commerce Department data indicate that average annual growth in total real dental expenditures adjusted for inflation was only 1 percent annually from 1979 to 1989. This was substantially less than the growth in medical expenditures. This slower growth in dental expenditures is estimated to have resulted in savings to the American public more than \$39 billion in 1990 dollar, from 1979 through 1989. Increased emphasis on prevention, widespread use of fluorides and sealants, and a better informed public contributed to those cost savings. These cost savings could increase exponentially if more Americans had access to preventive oral health services. In fact, the Institute of Medicine reports that 50 percent of all Americans do not receive regular dental checkups. Furthermore, while 37 million Americans lack medical insurance, the National Dental Research Advisory Council estimates that 150 million Americans lack dental insurance and millions more are underinsured. Dental caries or tooth decay, gingivitis and periodontitis, which are gum and bone disorders, are the most common oral diseases. Nearly half of all employed adults have gingivi-

tis, and 80 percent have experienced periodontitis, according to the U.S. Preventive Services Task Force.

If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance and possible systemic infections. Indeed, as many as 4 to 15 percent of American adults and more than 40 percent of the elderly have lost all of their teeth. Such individuals frequently experience nutritional deficiencies as a result of being unable to chew foods.

Each of these disorders, dental caries, gingivitis, and periodontitis, can be prevented through regular preventive care.

Children, in particular, should be assured regular preventive oral health services. The Medicaid EPSDT program has recognized the value of such services by mandating that all covered children receive preventive oral health care. Although the prevalence of dental caries among school-age children has declined in recent years, 84 percent of 17-year-olds were found in a recent NIDR survey to have cavities. Further, the Centers for Disease Control reports that the oral health of African-Americans and Hispanics is far worse than that of whites. For example, some of the most severe forms of gum disease disproportionately affects teenage black males and can result in loss of all teeth before adulthood.

In conclusion, preventable oral diseases still afflict the majority of children and adults in our Nation, compromising their health and unnecessarily adding to health care costs. Ideally, all Americans should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But at a very minimum, Americans need access to basic preventive oral health care, including education and self-care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance, and x rays. Any Federal legislation that provides for preventive oral health benefits also must ensure Americans' access to dental hygienists, the primary providers of preventive oral health services.

ADNA stands ready to work with the Nation's policymakers to ensure every American basic oral health and the savings of billions of health care dollars.

Thank you.

[The following statement was subsequently received:]

**WRITTEN STATEMENT OF JANE L. KENDALL, RDH, CAE**  
**on behalf of**  
**THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION**

**BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS**  
**SUBCOMMITTEE ON HEALTH**  
**MARCH 30, 1993**

**On Consideration of Benefits for Inclusion**  
**In a Standard Benefit Package**

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 licensed dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support total health through the promotion of optimal oral health. These services may be provided in independent and collaborative relationships with clients and other health care providers.

ADHA is pleased that reform of the nation's health care delivery system is one of Congress' highest domestic priorities. We are committed to participating in this process to ensure universal access to cost-effective quality health care, including, at a minimum, preventive oral health services. Oral health is a part of total health and the oral health care delivery system requires reform along with the medical care delivery system.

Access to Oral Health Care

The Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. Further, while 37 million Americans lack medical insurance, the National Dental Research Advisory Council reports that 150 million Americans lack dental insurance, and millions more are underinsured for health care, including oral health care.

Preventable oral diseases currently afflict the majority of children and adults in our country. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. Furthermore, nearly half of all employed adults have gingivitis and eighty percent have experienced periodontitis, according to the U.S. Preventive Services Task Force. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Indeed, as many as four to fifteen percent of American adults, and more than forty percent of the elderly, have lost all their teeth. These individuals frequently experience nutritional deficiencies as a result of being unable to chew food. Each of these oral health disorders -- dental caries, gingivitis and periodontitis -- can be prevented through regular preventive care.

Universal access to oral health services should be provided to all Americans as one way to support total health. Ideally, everyone should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Children, in particular, should be assured regular preventive services. The American Academy of Pediatrics supports a fully funded preventive care benefit package -- which includes preventive dental care -- as a component of its recommended basic benefit package for children. The Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program also recognizes the value of preventive oral health care for children, mandating coverage of these services for all Medicaid-eligible individuals from birth to age 21. Because of financial and other restrictions imposed by states, however, the September 1989 "Public Health Service Workshop on Oral Health of Mothers and



Children" revealed that the Medicaid program continues to serve only a fraction of the children it was intended to serve.

Preventive oral health care has already proven beneficial. The National Institute of Dental Research (NIDR) reports that one-half of American children ages five to seventeen are now cavity free. Although the prevalence of dental caries among school-aged children has declined in recent years, 84 percent of 17-year olds were found in a recent NIDR survey to have cavities. Further, the Centers for Disease Control reports that the oral health of African Americans and Hispanics is far worse than that of whites. For example, one of the most severe forms of gum disease -- localized juvenile periodontitis -- disproportionately affects teenage black males and can result in loss of all teeth before adulthood.

Americans with access to preventive dental services highly value this care, as illustrated by federal government workers. The Washington Post recently reported that 1.5 million of the four million current and retired federal workers who participate in the Federal Employees Health Benefits (FEHB) program choose the Blue Cross-Blue Shield policy, in part because of its preventive dental package, which includes dental exams, X-rays, prophylaxis (cleaning) and fluoride treatments. In addition, Hewitt Associates (Hewitt), an international consulting firm specializing in employee benefit plans, reports that 92 percent of the health plans in its data base include dental coverage.<sup>1/</sup> Hewitt also reports that employees ranked dental coverage second in importance only to medical coverage and before all other benefits, including paid time off, pension options, sick leave and life insurance.

#### Cost Savings Associated With Preventive Oral Health Care

Investing in America's oral health care will translate directly into fiscal savings. It is a known fact that preventive care can reduce the need for expensive critical care. In fact, NIDR reported in July 1992 that Americans saved nearly \$100 billion in dental bills during the 1980s because of improvements in oral health.

Remarkably, while economic factors, such as population growth, increases in numbers of dentists, and increases in numbers of Americans with dental insurance, might have significantly increased the growth in dental expenditures over the past decade, National Income and Product Accounts data from the U.S. Commerce Department indicate that average annual growth in total real dental expenditures, adjusted for inflation, was only one percent annually from 1979 to 1989. This was substantially less than growth in medical expenditures. This slower growth in dental expenditures is estimated to have resulted in savings to the American public of more than \$39 billion in 1990 dollars from 1979 through 1989. Increased emphasis on prevention, widespread use of fluorides, and a better-informed public contributed to those cost savings.

Even with these savings, however, there is room for significant improvement. In fact, the American Fund for Dental Health reports that 20 million work days are lost annually due to oral health problems. Increased access to preventive oral health services undoubtedly would reduce this staggering number and exponentially increase cost savings.

A working draft report prepared by the Public Health Service's Oral Health Coordinating Committee entitled "An Essential Oral Health Benefits Package" estimates an annual per capita cost of \$74 to provide all American children with comprehensive

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<sup>1/</sup> Hewitt Associates' March 30, 1993 testimony before the House Ways and Means Subcommittee on Health, "HealthCare Reform: Consideration of Benefits for Inclusion in a Standard Benefits Package," stated that it maintains a data base covering the salaried employees of over 1,000 major employers and the hourly and union employees of more than 200 major companies. These employers provide benefits to more than 20 million employees and 35 million of their spouses and dependents.

oral health services<sup>2</sup> and all American adults with only acute emergency and preventive services.<sup>3</sup> Thus, the estimated cost of providing these services would be \$19.2 billion for the entire population or \$11.8 for the 160 million Americans who presently lack dental insurance. The report further estimates that extending comprehensive coverage to all Americans would entail a per capita cost of \$134 or \$34.9 billion for the entire population or \$21.5 billion for the dentally-uninsured. [See attached table.]

#### Role of Dental Hygienists in Providing America's Oral Health Care

As the primary providers of preventive oral health services, dental hygienists stand ready to aid the nation in improving its delivery of oral health care and subsequently contributing to total health by providing valuable services such as routine prophylaxis; periodontal assessment, treatment and maintenance; application of fluorides and sealants; x-rays; and education in self care. By helping patients modify personal health behaviors to promote self care, dental hygienists assist individuals in playing a vital and cost-effective role in their own oral health.

As Congress reforms the health care delivery system, lawmakers thus should not view dentists as the gatekeepers of oral health services, akin to the primary care physician whose status may be elevated to that of gatekeeper of the provision of medical services in the future. The role of a dentist in the delivery of oral health care is not akin to that of a primary care physician. The preventive oral health services which ADHA is advocating be included in a standard benefits package should be available to all Americans when provided by any state licensed provider. Both dental hygienists and dentists' are licensed in all 50 states and therefore have demonstrated their competence to the satisfaction of state licensure boards whose mission it is to ensure the health, safety and welfare of the public. Further, dental hygienists receive three times the amount of education in preventive oral health services as do dentists.

Federal legislation should ensure direct access to dental hygienists by providing for direct reimbursement in order to maximize Americans' access to preventive oral health care services. We must break down arbitrary practice setting barriers to access which have long tied oral health care delivery to the fee-for-service private dental office, where only 50 percent of the population is served. Several states, including Colorado and Washington, have endorsed direct access to dental hygienists through legislation which permits dental hygienists to practice independently. These states expressly have recognized that full utilization of the services of dental hygienists can address the need to augment the delivery of oral health care. Federal law in no way should impede the progress that states are making in recognizing that dental hygienists appropriately may provide preventive oral health services outside of the purview of a dental office, thus breaking down the barriers which have impeded access to oral health services for too long.

A 1987 Federal Trade Commission study entitled Restrictions on Dental Auxiliaries, An Economic Policy Analysis recommends the elimination of licensing laws which limit the number of dental hygienists in a dentist's practice, finding that increased

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<sup>2/</sup> Services recommended include professional oral health assessment, consisting of thorough examination of the hard and soft tissues of the oral cavity and related structures provided on an annual basis, for those age two and older; dental sealants for permanent molar teeth in children; professionally-applied topical fluoride provided up to twice a year for children and adults who are assessed to be at risk for dental caries; oral prophylaxis (cleaning) for the removal of hard and soft deposits and extrinsic stain; and fluoride supplements made available to children until age 13 whose water supply contains sub-optimal levels of fluoride, acute emergency dental services, dental restorative services, and periodontal maintenance services.

<sup>3/</sup> Adult preventive services would include oral health assessment, oral prophylaxis, periodontal maintenance services, professionally-applied topical fluoride for adults at risk for dental caries, and acute emergency dental services.

use of dental hygiene services will decrease costs to the consumer and improve access, without compromising quality. It is critical for federal legislation to buttress, and not impede, state law efforts to ensure increased access to dental hygiene services for children, the elderly, minorities, the poor, and the traditionally underserved. As such, any federal legislation that provides for preventive oral health care services must protect patients' direct access to dental hygienists by providing for direct reimbursement.

### Conclusion

In conclusion, preventable oral diseases still afflict the majority of children and adults in our nation, compromising their health and unnecessarily adding to health care costs. Ideally, all Americans should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, Americans need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays. Any federal legislation that provides for preventive oral health benefits also must ensure Americans' access to dental hygienists, the primary providers of preventive oral health care services.

ADHA stands ready to work with the nation's policymakers to ensure every American basic oral health and the savings of billions of health care dollars.



From a working draft report entitled "An Essential Oral Health Benefits Package;" Oral Health Coordinating Committee; Public Health Service

TABLE IV. Oral Health Benefits Package  
Primary Preventive, Acute Emergency & Early Intervention Services  
Targeted for Children, Adolescents, Adults, and Seniors

Basic Oral Health Services	Targeted Population	Provider-Based Services (Guidelines / Modifiers / Estimated Costs)				
		Frequency of Service (Y/Year)	Utilization Rate	Specific Modifier	Estimated Unit Cost (\$/Unit)	Estimated Annual Per Capita Cost
Oral Health Assessment	Children / Adolescents & Adults / Seniors					
• Oral examination		1	70 %	—	\$23	\$15
• Dental radiographs		1	70 %	—	\$17	\$ 9
• Patient counseling		1	70 %	—	\$16	\$ 5
Dental Sealants	Children & Adolescents <sup>a</sup> (3 and 14 years)	1	50 % <sup>d</sup>	4 molars <sup>e</sup>	\$19	\$38
Professionally-Applied Topical Fluorides	Children & Adolescents (Non-Fluoridated Areas)	2	85 % <sup>f</sup>	45 % <sup>g</sup>	\$16	\$12
	Children & Adolescents (High Risk — Fluoridated Areas)	2	20 % <sup>h</sup>	55 % <sup>i</sup>	\$16	\$ 4
	Adults (High Risk of Caries)	2	70 %	10 % <sup>j</sup>	\$16	\$ 2
	Seniors (High Risk of Caries)	2	70 %	10 % <sup>j</sup>	\$16	\$ 2
Oral Prophylaxis	Children & Adolescents	1	70 %	60 % <sup>k</sup>	\$28	\$12
	Adults & Seniors	1	70 %	40 % <sup>l</sup>	\$39	\$ 11
Fluoride Supplements (Daily Supplemental)	Children 13 years and under <sup>m</sup>	1 (daily)	85 % <sup>f</sup>	45 % <sup>g</sup>	\$16	\$ 6
Acute Emergency Dental Services	Children / Adolescents & Adults & Seniors					
• Emergency Examination		1	100 %	15 % <sup>n</sup>	\$23	\$3
• Sedative Filling		1	100 %	2 %	\$31	\$1
• Emergency Tx of Pain		1	100 %	2 %	\$34	\$1
• Extractions (single tooth)		1	100 %	10 %	\$47	\$5
• Extractions (surgical)		1	100 %	1 %	\$86	\$1
• Traumatic wound Tx		1	100 %	1 %	\$55	\$1

Mr. KLECZKA. Thank you very much, Ms. Kendall.

There is a vote on the House floor right now, so what I would like to do is take a seventh-inning stretch and recess for about 15 minutes. I suspect there will be two votes in a row, so it will take about 15 minutes before we can conclude that.

So the committee will be in recess.

[Recess.]

Mr. KLECZKA. The subcommittee will come to order.

We will continue with the last panel. Our next speaker will be Dr. Jack Dillenberg, from the Coalition for Oral Health.

Doctor Dillenberg.

**STATEMENT OF JACK DILLENBERG, D.D.S., M.P.H., MEMBER, COALITION FOR ORAL HEALTH, AND PRESIDENT, AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY**

Dr. DILLENBERG. Thank you, Mr. Chairman.

My name is Jack Dillenberg, and I am president of the American Association of Public Health Dentistry, and I have directed public health dental programs and dental clinics for over 15 years.

I am here today representing the Coalition for Oral Health, a coalition of 14 national organizations which includes minority dentists, public health professionals, patient advocates, and dental educators and researchers.

The coalition was formed because we see people who suffer from serious oral diseases but do not have access to services. We are here to ask that modest primary and preventive oral health care benefits be included in a basic benefits package for the public and private system.

Imagine waking up one morning with excruciating pain in your hand, with an abscess on your finger. You go to your doctor and she tells you she can take care of it, but your health insurance will not cover it, they don't cover finger problems. Why should we accept exclusions based on parts of the body? This is exactly the situation with oral health care. The mouth very often is not considered part of the body.

Not everyone sees these tragedies. As with health care, the poor, minorities, unemployed and elderly lack access to care, and these are the people who have most of the dental disease. Unfortunately, oral diseases are not equal opportunity diseases. They are not proportionally distributed. Among school-age children, 25 percent of the children experience 75 percent of the decay. In most cities, the number one reason for referral to the school nurse is dental disease.

We are grateful for the committee's leadership in recognizing access problems, but clearly the system is not working. Over 150 million Americans have no dental insurance; 80 percent of Medicaid eligible children do not receive oral health services; and 50 percent of the homebound elderly have not seen a dentist in over 10 years. That is unacceptable.

And oral cancer is more common than leukemia, cancers of the brain, liver, bone, stomach, and ovarian and cervical cancer. Of all cancers, the greatest discrepancy between African-American and white survival rates is for oral cancer. Why? Because of delayed detection and treatment.

Dental health is also important if you are looking for a job. For example, an unemployed man had an infection in his upper front tooth. A public program that he was enrolled in would only pay for extractions and he did not want to have the tooth extracted while interviewing for a job. He got his pain killers and medication, but spent 8 days trying to find appropriate help. He lost 12 pounds and was too weak to continue his job interview search. His wife pleaded with an adjacent jurisdiction's health department and was able to get special permission for him to be treated and he is now employed.

This is not an isolated case. In Maryland, the welfare department recognized the need for their clients to have dental care in order to be employable. They set up a special program with the University of Maryland Dental School to do just that.

Outreach and educational efforts are important, but will not solve the problem for those who cannot afford care. An example of pent-up demand for care was seen at a municipal demonstration project which made dental care available for senior citizens. When three of the city's senior centers were informed of the program, it led to a 2-year waiting list. There is no dental safety net. Emergency rooms provide pain killers and antibiotics, but do not provide simple early treatment.

Recently, a young African-American man with an abscess in an upper molar tooth was hurting for 2 to 3 months, because he could not afford care. His face started to swell, he went to a dentist but could not afford the treatments. The infection spread through the sinus, and the pain and swelling continued. He went to a hospital emergency room and was ultimately admitted, and the next morning awoke with no vision in his right eye. So much pressure and infection was in the sinus that it compressed the optic nerve, causing irreversible sight loss.

In conclusion, Mr. Chairman, we agree with our colleagues that the dental marketplace is not the issue. It is the oral health of millions of uninsured and underinsured Americans that we are concerned about. Unfortunately, when it comes to the dental care marketplace, they can only window shop.

We need your continued leadership and help.

Thank you.

[The prepared statement follows:]



**STATEMENT OF  
THE COALITION FOR ORAL HEALTH  
SUBMITTED TO THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
TUESDAY, MARCH 30, 1993**

**THE PROBLEM**

Imagine waking up one morning with an excruciating pain in your hand, going to your physician, and having her tell you that you have an abscess on one of your fingers. "I can treat it," she says, "but I'm afraid your health insurance won't cover it. They don't cover finger problems." Most of us would think this was a pretty strange form of health insurance. If, as most of us now believe, exclusions based on pre-existing conditions, age, and occupational category are wrong, why should we accept exclusions based on parts of the body?

That is exactly the situation that exists today with respect to oral health care. The mouth is not considered part of the body. While we would be appalled at excluding limbs and organs from coverage, we seem to accept most casually the exclusion of the entire human mouth. If you have an abscess on your leg, your arm—even your face—no problem, you're covered. If that abscess happens to be in your mouth, inches from your brain, you're out of luck. This is not rational.

Oral diseases and other oral conditions—dental caries (tooth decay), periodontal (gum) disease, oral cancer, and tooth loss are among the most prevalent of all chronic health conditions. By the time they graduate from high school, 84 percent of all children have experienced tooth decay.<sup>1</sup> By the time they have reached middle age, adults have had more than half of their teeth affected by decay.<sup>2</sup> Eventually, almost the entire adult population experiences decay.<sup>2</sup>

Over 90 percent of all school-age children need care for the prevention or treatment of gum disease;<sup>3</sup> nearly 60 percent of 14-17 year-olds have evidence of bleeding gums,<sup>4</sup> and depending upon the age group, from 40 to 70 percent of adults have infected gums.<sup>2</sup> More than a third of adults over age 65 have lost all of their teeth.<sup>5</sup>

Each year, there are approximately 30,000 new cases of oral cancer diagnosed, and about 8,000 persons die from it.<sup>6</sup> This makes oral cancer more common in older Americans than leukemia, melanoma, Hodgkin's disease, and cancers of the brain, liver, bone, thyroid, stomach, and ovaries.<sup>6</sup> And surprising to many is the fact that oral cancer kills more Americans every year than cervical cancer.<sup>6</sup> Dental professionals are the health care providers most likely to have the first opportunity to diagnose and refer for treatment individuals with oral cancer. Yet, although the disease is much more common in the elderly, older Americans are among the least likely to visit the dentist.<sup>5</sup>

We are all too familiar with the devastating effects the HIV epidemic has had upon our society. Because the earliest manifestations of HIV disease often occur in the mouth,<sup>7-9</sup> dental professionals play a critically important role in the early detection of this disease. Such early detection means earlier therapeutic intervention is possible, thus extending the productive lifespans of affected individuals and improving their quality of life. And, of course, early detection also reduces the opportunity for further transmission of HIV.

Unlike many medical conditions that are self-limiting (i.e., they run their course without the necessity of a medical intervention) untreated oral diseases typically become more serious, more difficult, and more expensive to treat. The consequences of not treating oral disease extend well beyond the more obvious oral health consequences such as the severe pain of a toothache (which has been characterized as one of the most excruciating types of pain), and inability to chew food, to the more serious general health consequences of severe systemic infections, psychosocial problems, impaired nutrition and weight loss, severe disfigurement, and even death. Unfortunately, too often it is the poor, the elderly, the institutionalized, the geographically isolated, and the medically, physically, or mentally compromised who are the losers in their ability to gain access to the oral health services that most of us have come to take for granted.

The effects of oral disease go beyond the pain, discomfort, and dysfunction already mentioned, and claim a considerable economic toll on society. For example, over 20 million days were missed from work and over 51 million hours were lost from school in 1989 as the result of dental conditions.<sup>10</sup> And

even when productivity and classroom time are not jeopardized because workers and children are unable to take the time off to deal with their dental problems, it takes little imagination to see how work and school are still adversely affected by oral health problems. The distraction of a toothache not only decreases productivity, but may jeopardize the safety of the worker and co-workers. Think about how focused on his work a machine operator would be if his tooth was throbbing with pain and he was woozy from pain medication. Similarly, every teacher knows that a child with a toothache is not going to be able to concentrate and learn with other students.

### LACK OF ACCESS

It has become almost trite to cite the oft-quoted statistic that 37 million Americans lack "health" insurance (the term itself illustrating how dental care is overlooked in discussions of health insurance). Much less widely known or appreciated is the fact that approximately 150 - 160 million Americans lack dental insurance,<sup>5</sup> that millions more are underinsured, and that the scope of services covered by dental insurance is narrowing. In 1989, more than 40 percent of all Americans did not visit a dentist at all during the preceding year,<sup>5</sup> but even this figure understates the true magnitude of the problem, since included in the 60 percent who *did* see a dentist are those who saw one solely for an emergency service, a tooth extraction, etc.

Although there have been dramatic improvements in the nation's oral health over the past several decades, these gains have not been realized equally by all Americans. Oral diseases are not "equal opportunity diseases;" that is, they are not proportionately distributed in the population. For example, dental caries (tooth decay)—the most prevalent of all chronic diseases—eventually afflicts almost the entire population. Among school-age children, however, about 25 percent of the children experience 75 percent of the decay.<sup>1</sup> And that 25 percent typically represents poor, minority groups, handicapped, and other underserved children—the very children whose access to oral health services is most restricted because of their family's income, ethnicity, or disabling condition.

One of the principal barriers to access to oral health care is cost—including: 1) the actual out-of-pocket costs to those who cannot afford them;<sup>2</sup> 2) costs to businesses to offer dental insurance as a health care benefit; and 3) perceived or anticipated costs by policy-makers fearful of adding a dental benefit. Dental care should not be excluded from discussions of health care benefit packages simply because it is not considered part of the health care delivery system. Neither should it be excluded from such discussions because it is perceived as increasing the cost of a basic benefit package beyond affordability. The reality is that national expenditures for dental care constituted only 5.3 percent of personal health care expenditures in 1992.<sup>11</sup> This represents a decrease from previous years, and this proportion is projected to continue to decline well into the next century. Ironically, it is the *least* expensive dental services—the preventive services—that are the most effective in preventing and controlling oral disease, resulting in long-term cost savings to both individuals and to society. Definition of a basic set of oral health benefits for *all* persons, with a heavy emphasis on preventive services, is an important prerequisite for improving the general health of the American people.

There is a perception that the vast majority of Americans have no problem whatsoever with access to dental care, and that there is a relatively small segment of society who do need assistance with access, but are largely served by the existing "safety net" of Medicaid, Medicare, and public hospitals.

With respect to the "safety net" health care provisions of Medicaid, surely none has fared worse than dentistry. Despite the fact that dental benefits are federally mandated for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, *fully 80 percent of Medicaid children fail to receive any dental services.*<sup>12</sup> And, while expenditures for *every other* service category in Medicaid *increased* between 1975 and 1990, expenditures for dental services *decreased* by almost 30 percent over the same period.<sup>11</sup> Because Medicaid dental services for adults are considered optional, some states provide no dental coverage for adults, most states provide only emergency or very limited restorative services, and more and more states are considering eliminating adult dental services as the country's economic situation continues to strain state Medicaid budgets.

Medicare, which has done so much to improve and maintain the health of older Americans, is an empty promise as far as dental care is concerned. Only in the most extreme of circumstances (e.g., some jaw surgery not involving the teeth) is any dental care covered under Medicare. Indeed, the exclusion of dental benefits from mandatory health care benefit packages is often justified on the basis of oral health services being so limited under Medicare. Unfortunately, the Medicare legislation as originally conceived included dental coverage, but it was removed. Since then, we have come to recognize the problems that result from disenfranchising the mouth from the rest of the body and hope that these problems will be addressed through health care reform. As long as policy-makers continue to deny the obvious—that the mouth *is* part of the body—both the oral health and the overall health of the American people will continue to be at risk.

The failure of the Medicare program to cover oral health services is particularly disturbing given the fact that the elderly are among those most adversely affected by lack of adequate access to such services. While the percentage of adults with insurance increases until retirement age, the proportion begins to decrease from that age on. By the time they are 65, only 15 percent of older Americans have any dental insurance.<sup>5</sup> Another indicator of the plight of one subset of the elderly is that 50 percent of the homebound elderly have not seen a dentist in over 10 years.<sup>13</sup> People who, consciously or not, mean "medical care" when they think "health care," tend to think of hospital emergency rooms as "safety net" facilities for the uninsured. The reality is that is much less the case when it comes to persons with dental problems. Hospitals are typically equipped to provide painkilling medication and antibiotics for oral injuries and infections, but, due to the current system, relatively few hospitals have dental facilities or staff. Generally, a relatively benign, easy to treat oral health condition must be allowed to become a medical condition or medical emergency before a hospital can do anything about it. In the case of an infected tooth, by the time this happens, often the only treatment is extraction of the tooth. The medical analog might be a sliver in a finger that becomes infected. If treatment of such infections weren't a covered benefit, the infection would be allowed to progress to the point that the finger had to be amputated. Six months later the same thing could happen with a different finger. A health care system that dealt with fingers this way would not be considered rational. Is a health care system that treats teeth this way any more rational?

Some argue that routine dental care can easily be paid for out-of-pocket. Those who make this assertion are typically well-educated, employed, and insured individuals who have enjoyed the benefit of preventive and primary oral health care since early childhood. For these individuals, maintaining their oral health has become both routine and affordable. Unfortunately, this is not the case for those who are unemployed or underemployed, who are less educated, and whose financial means are more limited. It is important that we keep reminding ourselves that those who are most likely to have oral disease are least likely to have the means to pay for either its prevention or treatment. Those who argue that routine and inexpensive preventive and treatment costs should be excluded from a basic health care benefit package would do well to consider the medical analogy should routine immunizations and inexpensive pediatric care also be denied?

### PREVENTION/PRIMARY CARE

Perhaps the greatest irony surrounding the extensive oral health problems and lack of access to dental care faced by so many of our people is the fact that they are so easily and inexpensively preventable. For no aspect of health care is the old adage, "an ounce of prevention being worth a pound of cure," so true as it is for oral health services. In fact, some community-based preventive oral health services, such as community water fluoridation, dramatically exceed that benefit/cost ratio.<sup>14</sup> Children who live in fluoridated communities continue to experience as little as half the new tooth decay of children living in non-fluoridated ones. Fluoridation remains one of the greatest prevention bargains of all time: at an average cost of 51 cents per person per year, the *lifetime* cost of this cornerstone public health measure is about the same as the cost of *one* filling.<sup>15</sup> While about 60 percent of the U.S. population on public water supplies currently enjoys the benefits of fluoridation, 153 cities of over 50,000, with a combined population of 21.3 million, remain unfluoridated.<sup>16</sup> Ninety-three of these cities are in California.

We believe it is important not to forget such community and school-based preventive and public health programs as we develop a comprehensive health benefit package, because these types of programs are the preventive foundation that will make a modest oral health benefit package affordable. Additionally, these efforts require parallel strides in dental research and professional training in developing national health care strategies that will assure equitable access to care at affordable prices.

One difference between medicine and dentistry is that dentistry has a formidable, extensive, well-researched, and cost-effective set of preventive procedures to draw upon. For example, it is well known that the use of fluorides and dental sealants can prevent almost all tooth decay for children.<sup>14</sup> Regular effective removal of dental plaque through toothbrushing, use of dental floss, and regular prophylaxes (cleanings) can effectively prevent and control most periodontal diseases. Early detection of oral cancer can markedly increase survival rates and limit disfigurement.<sup>6</sup>

While overall the oral health status of the U.S. population is improving for those with access to oral health services, oral diseases continue to affect most Americans. Because dental problems are generally not reversible or self-limiting, and only get more difficult, time-consuming, and costly to treat, the most sensible approach for dealing with them is through prevention.

Prevention in dentistry works. One reason it works is that most of the procedures do not require individual compliance, unlike many of the preventive practices promoted by medicine. According to the National Institute of Dental Research, nearly \$40 billion was saved on dental treatment costs in the 1980s because of improvements in oral health attributable to the widespread use of fluorides and



increased use of preventive services by practitioners.<sup>17</sup>

As important as prevention in dentistry is, it cannot stand alone. In epidemiological terms, it is necessary but not sufficient to maintain and control the oral health of the American people. To provide preventive services alone, without the concomitant provision of primary dental care services, would be the equivalent of providing children immunizations but no coverage for ear infections, strep throats, and broken arms. Both prevention and primary care are needed, in dentistry as in medicine, to maintain health and to control the costs of health care.

Too often, neither the impact of oral health on general health nor the benefits of integrating oral health with general health are realized. There is a great deal of national attention and funding support for research on cervical cancer. Yet oral cancer kills more Americans than cervical cancer. Dental professionals are trained to detect and diagnose oral cancer. They are far more likely to carefully examine patients' mouths than other health care providers. If regular oral examinations of older Americans are not a covered benefit in a national health care benefit package, many persons would be denied the opportunity to have this life-threatening disease detected early, thus reducing their life expectancy, and increasing the chances of disfigurement as the result of extensive surgery that could have been prevented. *Oral cancer, although it occurs in the mouth, is a threat to HEALTH, not just to oral health.*

As noted earlier, dental professionals are often the first health care providers to detect the changes in the mouth that represent the first indication of HIV infection. Again, they provide a vital HEALTH service, helping to assure that infected individuals are referred for counseling and into the medical care system for appropriate therapy and treatment. Through the early interventions afforded by their early detection of problems, HIV infected persons are able to lead longer, higher quality, and more productive lives. *The oral manifestations of HIV, although they occur in the mouth, are threats to HEALTH, not just to oral health.*

These are just two of many oral diseases and conditions with life-threatening consequences for HEALTH. Additionally, untreated oral disease: complicates the treatment of organ and bone marrow transplants (sometimes resulting in death);<sup>18-19</sup> can result in severe complications, e.g., pneumonia, urinary tract infections, fever, and generalized infections of the entire body; can cause infection of a defective heart valve (resulting in death 50 percent of the time);<sup>20-21</sup> and can impair the ability to eat or speak properly.

The integration of oral health care into health care, and of oral health care providers into the health care system, is slowly beginning to occur, but could be aided immeasurably by a national health care system that recognized its importance and advantages. For example, the federal government has already recognized the importance of integrated medical and dental care by funding a project to train dental professionals to be sensitive to behavior or symptoms suggestive of possible HIV infection, prior to any visible manifestations, and to make counseling referrals where appropriate. This will help gain even earlier access to the health care system for HIV infected persons, with all of the benefits noted earlier. Dentistry has a long history of screening and referral for a wide variety of other infectious diseases as well as hypertension screening and detection of child abuse.

## THE SOLUTION

We believe strongly that a basic package of preventive and primary health care benefits, including comparable oral health benefits, should be required to be available to all Americans as part of both public and private insurance programs, and should be available in both private and community-based settings.

Our recommended oral health benefit package is detailed below. In general, the benefit package we recommend is intended to incorporate the basic diagnostic, preventive, and treatment services that have been proven effective in preventing and controlling dental caries, periodontal infections, pain, soft tissue pathology, trauma, and orofacial defects. What we are recommending are some of the least costly and most cost-effective health services available.

### COALITION-ENDORSED ORAL HEALTH CARE "BASIC" COVERED BENEFITS

Of the 260 million people in the U.S., only 100 million are covered by dental insurance. The Coalition for Oral Health proposes that the following basic benefit package be mandated as part of the required health care benefit package for all eligible Americans.

Our cost estimates are based on the assumption that the federal government will pay for those who are without dental insurance and at or below 200 percent of the federal poverty level. Although more than

half the population seeks dental care annually, families with incomes below two times the poverty level have far lower rates of utilization.

1. Preventive Services

- A. Professional Oral Health Assessment. A thorough annual examination of hard and soft tissues of the oral cavity and related structures, including necessary radiographs and counseling, is covered.
- B. Dental Sealants. The chewing surfaces of permanent molar teeth are those that are most susceptible to tooth decay. Dental sealants, plastic coatings applied on these surfaces, offer the greatest protection against this decay. This service will be available once prior to age 10 for protection of the first permanent molars and once between ages 10 and 17 for coverage of the second permanent molars.
- C. Professionally-Applied Topical Fluoride. Topical fluoride application is a covered benefit for children and adults who are assessed to be at high risk for dental caries.
- D. Oral Prophylaxis. An annual dental cleaning is a covered benefit.
- E. Fluoride Supplements. This preventive prescription is available for children up to age 13 in areas where the fluoride level of the community's water supply is less than optimum.

2. Acute, Emergency Dental Services. Coverage includes services which eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial region.

3. Early Intervention Services (to maintain and restore function)

- A. Restorative Services. Dental fillings with FDA-approved materials, excluding metal castings and cosmetic services, are covered.
- B. Periodontal Maintenance Services. Basic, non-surgical periodontal (gum) therapy, beyond tooth cleaning and polishing, is covered for those 15 years and older.

4. Special Needs Patients. Special needs patients include, but are not limited to, those with developmental disabilities, regardless of age, birth defects (e.g., cleft lip/palate), genetic disorders (e.g., ectodermal dysplasia, Sjögren's Syndrome), and acquired medical disabilities from either traumatic, neoplastic, or infectious disease (e.g., tuberculosis, HIV, oral cancer). The benefit package includes those services required to assure special needs patients the above package of basic oral care and additional services they require to have a functional dentition, including, when necessary, hospitalization and general anesthesia, orthodontic care for handicapping malocclusions, and prosthodontic care for those with ectodermal dysplasias.

5. Dentures. Removable prosthodontics to restore function are included, using a phased-in approach. Initially, full dentures for adults are covered, limited to no more than one set every 8 years. Partial dentures would be phased in as rapidly as the system would allow.

Fundamental to our proposal is that any medically adjunctive oral health care is covered. Also inherent in the proposal is recognition that, if a dentist is licensed to provide a covered service in the health plan, then the dentist should be reimbursed in the same manner as any other provider.

While the oral health of many thousands of citizens would benefit from the provision of other dental procedures (e.g., crowns, bridges, and removable partial dentures), this benefit package, in the interest of containing cost, allows for only the most basic of dental services.

The total cost of this basic preventive and primary oral health package for children and adults is approximately \$7.1 billion. Based on the 50th percentile level of current private practice fees, we estimate that this very modest but effective package would cost approximately \$9 per person per month if the government were to assume all of the cost in addition to the amount it currently pays for dental Medicaid, of providing care for those currently uninsured, who are at or below 200 percent of the poverty level.

## COMMON ORAL HEALTH PROBLEMS EXPERIENCED BY CONSUMERS

Our testimony concludes with a few examples that were provided by Coalition members of patients who have suffered needlessly because of oral health problems. These are not isolated cases but rather are representative of the serious access problems faced by countless Americans on a daily basis.

### Adults

Middle class Americans live in fear that the loss or change of job means the loss of medical insurance. Seldom is dental care considered.

A 57-year-old woman, formerly in management with two Fortune 500 companies, was forced to exist on Social Security income after becoming disabled as a result of advanced rheumatoid arthritis. When she began to suffer from dental problems she sought the attention of her dentist, but could not afford the necessary plan of treatment. After paying her monthly installments for medical expenses, having undergone multiple surgeries, she was left with \$92 per month for food, rent, utilities, clothes, transportation, etc. As a result she had been forced to give up her home, sell all of her personal possessions, and live wherever she could.

She is currently experiencing increasing pain from dental infections, yet has no options. A local United Way agency is seeking a dentist who might be willing to donate time for this woman's care.

### Working Poor

As with medical insurance, those lacking dental insurance are often those who are unemployed or underemployed. A 37-year-old recently unemployed man in a midsized, midwestern city had discomfort from an upper front tooth, which was increasing in intensity. The public assistance program was limited to extractions with no tooth replacement. He did not want to lose a front tooth while in the midst of job interviews, so he kept trying to find treatment as the pain worsened. Finally a health department in another jurisdiction in which he did not qualify for care agreed to provide him temporary relief. Within days the pain re-occurred. He spent the next 8 days trying to find help. During the lapsed time period, he lost 12 pounds, developed a systemic infection, and had become feverish and weak. He had become too ill for job interviews and too weak to make his own telephone calls. In desperation, his former wife contacted the health department that helped him before and pleaded for help. Although there was a 6 month waiting time for care at that facility, special permission was granted by local health officials to provide this man the care he needed. The care has been completed, and he is now healthy and employed.

Had he gone immediately to a public hospital emergency room, a route many would have taken, he would have seen a physician — who could not treat the dental origins of the problem. He would have received pain medication and an antibiotic, all at a cost of hundreds of dollars of uncompensated care. The solution would have been temporary and the cycle would have soon begun again.

### Children

A Head Start program health coordinator noted a child in the program who was not socializing with other children, did not seem to comprehend the teacher's lessons, didn't respond to questions and didn't participate in group activities. In essence, this child was thought to be demonstrating asocial behavior. Coincidentally, this child eventually remained the only child in the program whose parent had not arranged for the required dental exam and follow-up care. When program staff got the child to a pediatric dentist, she discovered advanced decay, multiple abscesses, and broken off teeth with sharp edges. The problems were so severe that the child had to be treated under general anesthesia in a local hospital outpatient surgery department. Within one week after treatment, this little boy began to respond to the classroom teacher and play with the other children. We must consider the potential for diminished capacity to learn at best and aberrant social behavior at worst had this child not been able to get necessary dental care.

### Children with Special Needs

A child with ectodermal dysplasia, a condition in which many children never develop teeth, was able to receive a complete denture under the medical policy of a major health insurance company. In a different state, another child with the same medical condition had the same dental service denied by a subsidiary of the same parent insurance company because they said that "teeth are only cosmetic." This child was named the national poster child for Ectodermal Dysplasia and was to appear at many national events, with widespread media coverage. It was only when the parents told the insurance company that they would broadcast the company's indifference to this situation at these series of events, that the company reversed its decision.

### Developmentally Disabled

A young man with cerebral palsy and mental retardation had lived at home most of his life. His mother drove him to the closest dental school which was 110 miles away for his dental care. When she died, he was placed in a philanthropic nursing home. While he was able to continue medical care, there were no arrangements for dental care. When he suffered a toothache from advanced dental caries, there were no funds available to pay for the oral surgeon, the necessary anesthesiologist, and the operating room.



Fortunately, there was a dental staff member at the local health department who negotiated fees and was able to acquire necessary funds from a private foundation. Unless a funding mechanism is established, this patient and thousands of others will have to fight for every episode of needed care.

### Elderly

A cooperative agreement among the Robert Wood Johnson Foundation, HCFA, and health departments in five U.S. cities (from 50 applicants), provide for cost-reimbursed health care for a limited number of senior citizens. This program was significant because it waived deductibles and co-payments, and provided care not otherwise covered by Medicare, i.e., dental care, vision care, and podiatry services. One health department reports that before the community was made aware of the program only a very small number of the indigent elderly in the community sought dental treatment. After the program was initially announced at only three of the city's 50 senior recreation centers, demand so outstripped capacity that a two year waiting time was created and program promotion had to cease. This demonstrates the great unmet dental needs among the nation's elderly.

This city is not unusual. Many seniors suffer from a lifetime of cumulative needs which have a critical impact on their nutrition, self esteem, and overall health. Some are missing all of their natural teeth, decreasing their ability to chew by 75 percent, many are missing some of their teeth, while others have root decay, or have severe oral manifestations of systemic disease or oral problems caused by prescribed medications.

### Nursing Homes and Long Term Care Facilities

Residents of nursing homes across the country have little or no access to dental care. Although medical care is required for Medicare and Medicaid certification, nursing homes have more limited responsibility for dental care. They must assess residents' oral health and provide or obtain care—but without additional resources or dental insurance coverage for residents. Dental care costs have not been allowed in nursing home cost reports. Medicare does not include dental benefits and only a few state Medicaid programs include dental coverage for adults. Therefore, residents who cannot pay out of pocket for dental care usually do not receive care.

Because coverage is so poor and the providers who will care for these patients are so limited, a number of nursing home administrators in one state contracted with a mobile dental service in an attempt to arrange for dental services for their residents. The administrators frequently expressed complaints about the service, but had no alternatives. The corporation operating the service required that nursing homes allow access to all patients. However, the time that the dentist spent at the home seemed to be far less than needed for the number of residents. The service refused to provide information to the administrator or patients' families regarding the treatment that had been provided. Because they were "the only game in town," this population was literally held hostage. Two months ago, the owner/operator of this practice was convicted of Medicaid fraud and lost his dental license.

The director of a long term care facility which housed individuals with severe disabilities contacted a local health department seeking assistance to arrange for dental care for his residents. A public health dentist visited the facility and noted that nearly every resident needed dental care. One 23-year-old female for whom staff was especially concerned had not been eating and was lethargic. The dentist found her to have teeth rotted to the gums and multiple abscesses. Although surely suffering from intense pain, she did not have the ability to express the nature of her problem to the staff. It was determined that she would require a substantial amount of dental care in a hospital setting under general anesthesia and that the family lacked the funds it would cost for the operating room. It was two weeks before arrangements could be made within the system so that this woman could receive the care that she needed.

This is an example of a case in which hundreds of thousands of dollars have been spent over this woman's lifetime to support her existence, yet the absence of necessary treatment of her oral infections placed her welfare, and potentially even her life, in jeopardy.

## **COALITION FOR ORAL HEALTH MEMBERS**

**AMERICAN ACADEMY OF ORAL MEDICINE** The AAOM was established to combine the knowledge and skills of dentistry and medicine to promote total health care. Members' practices are involved with the diagnosis and treatment of diseases which primarily and secondarily affect the oral cavity and its adjacent structures and care of the medically compromised.

**AMERICAN ACADEMY OF ORAL PATHOLOGY** The American Academy of Oral Pathology represents the specialty of dentistry that provides clinical and laboratory services to private practitioners, institutional and hospital dentists, physicians, and pathologists. Their services are critical for development of a primary health care program that emphasizes early detection and prevention of cancer, the oral management of AIDS patients, and the early detection and management of transmissible infectious diseases.

**AMERICAN ASSOCIATION FOR DENTAL RESEARCH** The American Association for Dental Research (AADR) represents over 4,500 professionals involved in oral health research throughout the United States. The association promotes research to improve oral health worldwide and fosters dissemination of scientific advances relevant to oral health. The association facilitates communication, collaboration, and research training and education within the scientific community. The AADR is a Division of the International Association for Dental Research.

**AMERICAN ASSOCIATION OF DENTAL SCHOOLS** The American Association of Dental Schools represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted.

**AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS** The American Association of Oral and Maxillofacial Surgeons represents the 6,000 oral and maxillofacial surgeons in private practice and whose members provide extensive hospital-based oral surgical care in the United States.

**AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY** The American Association of Public Health Dentistry represents the specialty of dental public health. It has a diverse membership of oral health professionals. AAPHD's primary focus is to improve the oral health of the public, using principles and methods of public health practice.

**AMERICAN DENTAL TRADE ASSOCIATION** The American Dental Trade Association founded in 1882, represents dental distributors; the Dental Laboratory Conference (leading dental laboratories) and dental manufacturers. The objectives of ADTA are to promote and encourage the development, production, and distribution of equipment and materials for the dental profession, dental schools, and dental laboratories so as to enable its members to perform the highest degree of useful service for the public health and welfare.

**AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN** The American Society of Dentistry for Children is the oldest advocacy group within dentistry for promotion of oral health for children in the United States. Its distinguished history goes back to the middle 1920s and it remains today a coalition of specialists of pediatric dentistry, generalists interested in childcare, and specialists in other fields of dentistry who deeply believe that the dental profession must always focus on preventive dentistry for the child patient population and for the reclamation of dental health for dentally diseased children.

**ASSOCIATION OF COMMUNITY DENTAL PROGRAMS** The Association of Community Dental Programs is an organization comprised of dental directors and dental program personnel of local and county health department and staff of any other community based dental public health programs. The mission is to assure access to dental prevention and treatment services to all constituents in a cost effective manner by minimizing duplication and sharing information and methods.

**ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS** The Association of State and Territorial Dental Directors is a voluntary professional organization whose members are the directors for public oral health programs in the states and U.S. territories. ASTDD is an affiliate of the Association of State and Territorial Health Officials.

**FEDERATION OF SPECIAL CARE ORGANIZATIONS IN DENTISTRY** The Federation of Special Care Organizations in Dentistry is an umbrella organization for the American Association of Hospital Dentists, Academy of Dentistry for the Handicapped, and the American Society for Geriatric Dentistry. The federation joins together organizations of like missions to stimulate teaching, education, research, and patient care for special patient populations including the mentally and physically challenged, medically compromised, and the elderly and frail.

**NATIONAL ALLIANCE FOR ORAL HEALTH** The National Alliance for Oral Health is a coalition addressing the oral health needs of special patient populations. NAOH is a non-profit coalition of voluntary health groups, professional health-related organizations, and individuals who are united by their common concerns for the needs of special patient populations.

**NATIONAL DENTAL ASSOCIATION** The National Dental Association represents ethnic minority dentists and allied dental professionals in the United States and the communities they serve. Their mission is to improve the oral health status of the medically underserved and disenfranchised by increasing the number of minority providers, researchers, and educators.

**NATIONAL NETWORK FOR ORAL HEALTH ACCESS** The National Network for Oral Health Access is an organization of dental providers practicing in community, migrant, and homeless health centers with the goal of improving the health status of the unserved and underserved through improved and increased access to oral health care.

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Mr. KLECZKA. Thank you, Dr. Dillenberg.

I should add that your entire statement, which was much more comprehensive, will be made part of the record.

Dr. DILLENBERG. Thank you.

Mr. KLECZKA. Our next witness is Dolores Kordek, chairperson of the National Association of Prepaid Dental Plans.

**STATEMENT OF DOLORES A. KORDEK, CHAIRPERSON, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF PREPAID DENTAL PLANS**

Ms. KORDEK. Good afternoon, Mr. Chairman.

My name is Dolores Kordek, and I am a principal with U.S. Dental, headquartered in Phoenix, Ariz. However, I am here today as chairperson of the National Association of Prepaid Dental Plans.

The National Association of Prepaid Dental Plans is the trade association of 62 companies offering managed care dental benefits in 47 States. Our association is the only one that exclusively represents managed care dental benefits. This industry covers some 12 million people across the United States today through networks consisting of more than 23,000 dentists.

We have provided a 2-page detailed statement to the subcommittee. This document is focused on determining whether the same crisis in availability and affordability that exists today in medical care exists in dental care. Let me just cite a couple of facts from that document.

In 1992, medical benefits had the lowest increase in several years, but still grew by 10.1 percent. A survey of dental benefits for 1992 marks the increase in dental benefit costs at 5 percent for individuals and 6 percent for families. Dental benefits costs for individuals and families are about one-twentieth of that of medical, according to these surveys.

Dental services overall are decreasing as a percentage of national health care expenditures, projected at only 4 percent of the total by the year 2000. Prepaid dental plans offer coverage at rates on average 30 percent less than indemnity coverage, with greater benefits and lower out-of-pocket costs. Prepaid dental plan rate increases have generally been below 6 percent in the past few years. In fact, last year, one in four plans had no rate increase.

Dental coverage does not have the widespread catastrophic limitations on preexisting conditions which effectively eliminate individuals from medical coverage. Nine out of ten employers of 100 or more employees offer dental benefits coverage.

According to a 1991 U.S. Chamber survey, 76 percent of all employers offer and 51 percent of employers of all sizes pay for dental coverage as an employee benefit. The cost of that benefit is six-tenths of 1 percent of payroll. Prepaid dental plans offer coverage in 47 States, with options for individual, voluntary or employee paid payroll deduction and group of employer paid coverage.

These few facts and those contained in our detailed statement indicate that the financial crisis that exists in medical coverage and access to medical care in the United States today does not exist in dental coverage. Thus, we believe that dental care should not be swept into Federal medical care reform at this time, and that careful expansion of the existing system, particularly the managed care

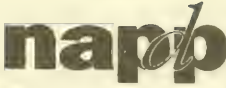
component, can adequately meet the needs of private nongovernmental consumers.

Other elements of the reform package may affect our industry. For instance, a GAO study shows that changes in the tax system could substantially reduce the demand for benefits. Such a change in demand could have the greatest negative impact on prepaid dental plans, which are the most rapidly expanding and cost-effective part of that market.

So we do hope that the subcommittee and members will take advantage of our unique perspective as the only association collecting statistics on managed care dental benefits, as other elements of reform are considered.

I offer the assistance of our association and its members in addressing your questions and concerns. Thank you for your time and attention. I will be happy to answer any questions.

[The prepared statement follows:]



## National Association of Prepaid Dental Plans

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### Position Paper: Inclusion of Dental in Federal Health Care Reform

March 30, 1993

Dolores A. Kordek, Chairperson  
Board of Directors

#### Is There a Crisis in Dental Care?

In analyzing whether dental should be included in the federal health reform package from a public policy view, it is necessary to examine the driving forces behind the health care debate and determine if comparable factors exist in dental care. Dental coverage should not be swept along without evaluating the differences between the market and other factors related to **medical** coverage and that of **dental** coverage. The key issues that have spurred the federal debate on health care reform have been the cost & availability of coverage for **medical** care as well as the potential catastrophic impact of the lack of coverage. These same problems do not exist in **dental** care.

#### The crisis with **high and rapidly increasing costs** that have beset the medical industry **do not exist in the dental industry:**

- The Foster Higgins 7th Annual *Health Care Benefits Survey* released March 2nd indicates that the cost of health benefits rose 10.1% on average in 1992 while the 1992 Hay Huggins report indicates that dental benefit costs rose only 5% for individuals and 6% for families on an annualized basis over the same period.
- The same Foster Higgins report places the average cost of medical plans per employee in 1992 at \$4080 for indemnity coverage, \$3,313 for hmo coverage, \$3,566 for point-of-service plans and \$3,708 for preferred provider plans. The 1992 Hay/Huggins report established the average monthly premium cost for employee only dental indemnity coverage in 1992 at \$16.62 (\$199 annually) with family monthly premium cost was \$45.72 (\$549 annually).
- Prepaid dental plan premiums average 30% lower than those for general dental indemnity coverage while the benefits provided are often broader by including full coverage of preventive and diagnostic care.
- About 70% of all prepaid dental plans have recently held rate increases well under the 1992 dental CPI increase of 6.8%. In 1992 one in four prepaid dental plans had no rate increase.
- By the year 2000, national health expenditures are projected at \$1.6 trillion. Dental services are projected to be less than 4% of the total expenditure.

#### The existing crisis in obtaining private, non governmental medical coverage is not occurring in dental coverage.

- Dental coverage does not have the widespread catastrophic limitations on preexisting conditions effectively excluding individuals from coverage.
- Dental coverage is generally available to the private purchaser throughout the United States through groups, payroll deduction, or individual/family coverage.
- According to Foster Higgins survey cited above, 9 out of 10 employers with 100 or more employees offer dental benefits coverage.
- Prepaid dental plans offer coverage in 47 states with options for individual, voluntary (employee paid payroll deduction) and group (employer paid) coverage. Approximately 12% of the 115 million people covered by dental insurance are covered by prepaid dental plans.
- Prepaid dental plans are actually expanding dental coverage with consistent 17%-25% annual growth over the past three years.



**The current problems of catastrophic impact from the lack of medical coverage are not applicable to dental coverage.**

- Dental care does not have the potential for a catastrophic financial and physical impact on families as in the case of medical care.
- Using the Foster Higgins data on medical benefit costs and the Hay Huggins data on dental benefits costs for comparison, dental premiums are generally less than 1/20th that of medical insurance premiums with lower out-of-pocket expenses.

### **Summary**

This outline demonstrates that the financial crisis that exists in medical care in the United States does not exist in dental care. While not being a part of the problem does not necessarily exempt an industry from being part of the solution, we believe that at this time dental care should not be swept into federal medical care reform. If action is taken without full consideration of the differences in the market for and delivery of dental care, unintended results could occur. Dental benefits lag substantially behind medical benefits in delivery through managed care systems. Changes in the tax system could substantially reduce the demand for dental benefits according to a GAO study. This reduction in demand could have the greatest negative impact on the growth of managed care dental benefits which are the most rapidly expanding and cost effective part of the market.

We recognize that even with exclusion from the benefit package, other elements of health care reform could affect our industry. The dental benefits industry, especially that portion that is having the most impact in containing costs, should be included in active discussion of the impact of all elements of reform on the dental benefits marketplace. In conclusion, let me reiterate, the dental coverage industry is not in crisis and careful expansion of the existing system, especially the managed care component, can adequately meet the needs of private, non governmental consumers.

Mr. KLECZKA. Thank you very much, Ms. Kordek, for your testimony.

Our last witness is David Schmehl, representing MIDA Dental Plans, in Southfield, Mich.

**STATEMENT OF DAVID E. SCHMEHL, VICE PRESIDENT OF NATIONAL RESEARCH AND DEVELOPMENT, MIDA DENTAL PLANS, INC., SOUTHFIELD, MICH.**

Mr. SCHMEHL. Good afternoon.

My name is David Schmehl. MIDA Dental Plans, the largest privately held dental plan administration company in the United States, is headquartered in Southfield, Mich. We appreciate the opportunity to be here today.

The current focus of health care reform is reducing costs through preventive care. No facet of health care can be so easily controlled through the utilization of preventive techniques as dentistry. For this fundamental reason, dental coverage should be an integral component of a basic health benefits package.

This may also at first glance suggest that only the preventive component of dental care should be included in such a package. Adopting such a policy would, in our view, be unwise. First, dental problems never correct themselves. While preventive care will reduce the incidence and severity of dental problems, those problems that are discovered must still be treated through restorative care.

Secondly, the exclusion of restorative care could, under some scenarios which we understand are being considered, result in the creation of a strong disincentive for employers to continue providing such restorative care benefits to their employees. Were that to occur, we believe that the end result would be the deterioration of dental health in general.

There is understandably concern over the potential cost of restorative dental care. MIDA would point out, however, that the high and ever-increasing cost of health care coverage and delivery in the medical sector, as well as the often almost limitless cost of catastrophic medical care, does not exist in the dental sector.

In 1992, the cost of dental coverage on an indemnity basis was less than one-tenth the cost of medical coverage, and premiums for dental HMOs averaged 25 to 30 percent less than traditional indemnity premiums, while providing increased benefits. We suggest that this is true because costs have been contained in the dental environment. Dental coverage is not only affordable, it is available throughout the United States. And because coverage is modeled after HMOs, most DMOs do not have preexisting condition limitations.

It is for these reasons that DMOs have seen consistent annual growth of 17 to 25 percent over the past 3 years.

While dental care and coverage are sufficient now, changes in current methods of delivery or taxation could alter things. Should a health care reform plan provide, for example, that only companies providing a full range of specified basic health benefits may market health coverage to employer groups or their purchasing representatives, companies such as ours could be excluded from the marketplace.

Because our only business is dental care, we have developed efficient, economical procedures for its delivery. Quality assurance is higher, while costs are lower. If companies such as ours are precluded from offering our services, these benefits will be lost.

At the same time, if dental care as a whole is excluded from the basic benefit plan, the cost of employer-sponsored dental care programs must continue to be deductible for tax purposes by employers. Otherwise, many employers will rethink their position and possibly eliminate their programs. Were this to occur, or were the employees' copayment obligations to be increased, many individuals would opt to forego the coverage and potentially the maintenance of their dental health. The positive strides made in the last 25 years would be jeopardized, as dental care received a lower priority.

In conclusion, MIDA believes that in order to avoid a general deterioration in the dental health of our citizens, both the preventive and restorative components of dental care must be included in a basic health benefits plan. Indeed, we believe this so strongly that exclusion of dental care altogether is preferable to inclusion of only preventive dental care.

Thank you very much for giving me the opportunity to present MIDA's views today.

[The prepared statement follows:]



## STATEMENT OF DAVID E. SCHMEHL, VICE PRESIDENT OF NATIONAL RESEARCH AND DEVELOPMENT, MIDA DENTAL PLANS, INC.

### Introduction

MIDA Dental Plans, Inc. (MIDA), the largest privately held dental plan administration company in the United States, appreciates the opportunity to present its views concerning why it is important that dental care be properly included in any uniform health benefits package to be considered for all Americans. Because dental care has become an integral part of the total health benefits packages offered by many employers, MIDA believes that such care deserves the consideration of the Subcommittee on Health as it determines the components of a national health benefits package.

Headquartered in Southfield, Michigan, MIDA has over 800,000 dental plan subscribers in 21 states, the District of Columbia, and the United Kingdom, and over 5,000 participating dentists in its Dental Maintenance Organization (DMO) and Preferred Provider Organization (PPO) plans. Founded in 1981, MIDA feels that it is thus well-qualified to provide meaningful and helpful information to the Subcommittee on this most important issue.

### Preventive Versus Restorative Dental Care

A current focus of health care reform is reducing cost through preventive care. By treating small problems while they are still small, it is hoped that larger, more costly problems can be avoided in the future. Dentistry lends itself fully to this approach. No other facet of health care can be so easily controlled through the utilization of preventive techniques. For this fundamental reason, dental coverage should be an integral component of a basic health benefit package.

Statistics have shown that more than sixty-nine percent (69%) of all dental services are either diagnostic or preventive in nature. The introduction of fluoridated water has been a strong deterrent to tooth decay. Education, beginning at the earliest stages of development, has effectively increased the retention of natural teeth. There is overwhelming evidence that preventive dentistry reduces the overall cost of dental care.

On the basis of the foregoing, it may at first glance appear prudent to consider including only the less costly preventive component of dental care in a basic health benefits package. Such a policy would, however, be extremely counterproductive.

First, unlike some disorders, dental problems will not correct themselves over the course of time. A cavity left untreated becomes only larger. While preventive action will reduce the incidence and severity of dental problems, those problems that are discovered must still be treated.

Secondly, the exclusion of restorative care from a standard benefits package could, under some scenarios which we understand are under consideration, result in the loss of a tax deduction by an employer for the cost of restorative benefits provided to employees and/or the inclusion of the value of the restorative benefits in employees' incomes.

Under either scenario, there would be a strong disincentive for employers to continue providing such restorative benefits to their employees. We believe that the end result would be the deterioration of dental health in general. A benefits program which includes both preventive and restorative coverage would, on the other hand, promote and improve dental health.

### Dental Care Efficiency

There is understandably concern over the potential cost of the inclusion of dental care, particularly the more expensive restorative component of that care, in a standard benefits package. MIDA would point out, however, that the apparent problem of

inefficient and ineffective health care coverage in the medical sector, as well as the almost limitless cost of catastrophic medical care, does not exist in the dental sector.

There is much evidence that the dental care industry has done an effective job in making dental care available and affordable to the general public. According to reports issued by Foster Higgins and Hay/Huggins concerning experienced costs for 1992, the cost of dental coverage, on an indemnity basis, is generally less than 1/10th the cost of medical coverage. In addition, the concurrent out-of-pocket costs are significantly less. More to the point, premiums for dental HMOs (DMOs) average 25 to 30% less than traditional indemnity premiums, while providing increased benefits.

This is true because costs have been contained in the dental environment. Foster Higgins reports that, in 1992, the cost of health benefits rose 10.1%, on average. At the same time, the dental component of the CPI was 6.8%. While that percentage may also appear to be high, it should be noted that much of the recent increase in dental care cost is attributable to government-mandated changes in the practice environment. New methods of sterilization and other protective measures put into place in order to comply with newly enacted OSHA regulations have had a dramatic effect on the cost of operating a dental practice.

On the whole, affordable dental coverage and care are available throughout the United States. Prepaid dental plans offer coverage in 48 states and the District of Columbia. Indemnity dental coverage is available in all jurisdictions. Programs are available to individuals as well as through employer and association groups.

With coverage modeled after HMOs, most DMOs do not incorporate preexisting condition limitations which tend to result in the exclusion of individuals from coverage. An indication of the availability and affordability of dental coverage is the fact that DMOs have seen consistent annual growth of 17 to 25 percent over the past three years.

#### Reform Must Be Carefully Thought Out

While dental care and insurance coverage do not appear to be suffering from inefficiency or ineffectiveness, changes in current methods of delivery or taxation could adversely affect the situation.

Should a health care reform plan provide, for example, that only certain federally certified companies which provide a full range of specified basic health benefits would be able to market health coverage to employer groups and/or their purchasing representatives, companies such as ours could be excluded from the marketplace.

Because our only business is dental care, we have developed many efficient, economical procedures for its delivery. We have provided a level of quality assurance which was previously not available. We have done this while at the same time reducing the cost of the dental care we provide. If companies such as ours are excluded from or disadvantaged in offering our services, those benefits will be lost.

At the same time, if dental care as a whole is recognized as an integral component of the health care system but is excluded from the basic benefit plan, the possibility exists that the cost of employer-sponsored programs would become non-deductible for tax purposes. This action would undoubtedly cause many employers to rethink their position and possibly eliminate their programs. At the very least, a large number would be converted to voluntary

programs, serving only to perpetuate the selective risk-taking practiced by some insurers today and, thereby, to increase costs for all.

Were employers to drop employee coverage or increase substantially the employee's co-payment obligations, many individuals would opt to forego the coverage and potentially the maintenance of their dental health. The positive strides made in the last twenty-five years would be jeopardized as dental care received a lower priority. Episodic care would more than likely replace preventive care since the cost would fall squarely on patients.

#### Conclusion

MIDA believes that, if dental care is to be included in a basic health benefits plan, both the preventive and restorative components of that care must be included, particularly if the reform package includes adverse tax consequences for those who provide or receive dental benefits in excess of those considered within the basic plan. Considering the general dental health of the population as a whole, MIDA believes that exclusion of dental care from the basic health benefits package (under the conditions set forth above and summarized immediately below) is preferable to inclusion of only preventive dental care.

If dental care as a whole is to be excluded from the basic benefits package, it should be accomplished in such a manner that (a) employers do not lose a tax deduction for the cost of dental care plans for their employees, and (b) employees do not have to include the value of such benefits (or premiums) in their income.

Finally, in view of the efficiencies brought to the dental marketplace by programs such as prepaid dental plans, any reform package should permit such plans to continue to offer their services.

Dental care does not suffer from the problems which have beset medical care. The application to dental care of sweeping reforms perhaps appropriate for medical care would have a negative effect upon our nation's dental care. By the same token, the well thought out, deliberate inclusion of preventive and restorative dental care in a uniform health benefits package would be advantageous to all.



Mr. KLECZKA. Thank you for your comments, Mr. Schmehl.

Let me ask two questions of the entire panel that the Chair has put to all folks who have testified today. In developing a basic health package, would you prefer or would you counsel us to have Congress put that together, or a private board or some other type of entity?

Dr. ZAPP. Our option, Mr. Chairman, would be for Congress to put the basic package together.

Mr. KLECZKA. You trust us and you like us.

Dr. ZAPP. We think you are more accessible.

Mr. KLECZKA. That could be a problem. [Laughter.]

The balance of the panel? I am getting a couple nods.

Mr. SCHMEHL. We would prefer that Congress make that determination, and if you choose to incorporate the recommendations of a board, that would be fine.

As far as the HIPCs go, it would depend on how those are structured. If we are excluded from participating, certainly we would be against it.

Mr. KLECZKA. And the second question the Chairman has been posing, would you prefer that the administration be through a HIPC or, as currently the practice, through an insurance carrier, third-party payer or something on that order?

Dr. ZAPP. I think, Mr. Chairman, the American Dental Association would prefer that the current delivery system, which is basically already a gatekeeper arrangement with 81 percent of the dentists delivering care in general private setting, as opposed to going into a health plan of some type.

Mr. KLECZKA. And having a cooperative dictate or whatever. Any other views form the panelists?

Dr. DILLENBERG. I think from the coalition perspective, we are focusing on the access to care issues and have not had a chance to review and form an opinion on the HIPCs.

Ms. KENDALL. We have real problems with the current delivery system, in that the outcomes demonstrate that people are not receiving care, and if 81 percent of the dentists are serving people in private settings and less percentage than that of people are receiving care, there is a delivery system problem. And I think we need to have a system that has providers be where people are and is not so setting bound. We have to have a system that gets to people and we do not have one now.

Mr. KLECZKA. It seems to me that all the panelists dealing with oral hygiene support inclusion in some type of a basic plan, unlike the dental association representatives I met before coming down, so I assume that you would be somewhat supportive of a managed competition type of a concept.

Now, knowing full well that standing alone managed competition does not save us two nickels from our current expenditure, and if in fact we would go universal coverage and provide dental, which would be an expansion of what we have today in this country, where would you folks suggest we get the additional dollars to pay for this? Again, standing alone, if we were to include the 35 million Americans with no health insurance, the Congressional Budget Office indicates that could be an additional expenditure of some \$50 to \$90 billion.

So it is a tough question and it is one which a panelist a couple of weeks ago said "that is your job, you are the Member of Congress." You know, if you are sitting here advocating a better health delivery or health care system for the country, I think we are in this together and we are going to have to look to you for some of the easy questions to be answered and also some of the hard ones.

Do any of the panel members care to get in trouble with their organization?

Dr. DILLENBERG. I think I may at this point, but I think that if Congress elects to invest in a primary care preventive oriented program for oral health services, clearly the benefits are there and can be realized.

I think there might be some up-front investment, but getting primary preventive oriented services out to a wide population, again, we have got 150 million people out there that don't have insurance, many of whom are not receiving any care at all.

And I think if we look at these folks that then are becoming a drain on what we call the traditional Medicaid system, where we cannot do the early simple treatment, and yet they go into emergency rooms, they get antibiotics, they get pain killers, and then all of a sudden the systemic problem develops where an individual gets ill and now qualifies for the Medicaid program, it is costing significant dollars. So I think the up-front investment in the primary preventive services in oral health care going to give tremendous benefits down the road for you.

Mr. KLECZKA. A great statement, but you forgot to answer the question. If, in fact, additional resources are necessary, doctor, do you have any guidance for this committee and for Congress as to how to amass those additional resources? You keep looking at someone and I hope it is not your wife. [Laughter.]

In fact, I am one who agrees with you. If we put this investment up forward, in the longrun we are going to save money and that is true of all preventive medicine and preventive care. The problem is, when our Congressional Budget Office costs it, there is a cost up front, and in 10 years we might have a relatively large cost savings, but that is not part of the calculation. So once this thing is developed and once it is drafted and passed, if in fact there is a shortfall of revenue, it is incumbent upon us to make up that shortfall.

Yes, Ms. Kordek?

Ms. KORDEK. I believe that was the reason the National Association of Prepaid Dental at this point selected a position of not proposing dental in the basic benefits reform package. Our feeling was that dental would add to the deficit, if you are trying to come up with funds to handle the most pressing problems.

Mr. KLECZKA. So your posture is continue with the prepaid private plans?

Ms. KORDEK. Private plans and encourage free enterprise alternatives.

Mr. KLECZKA. How broad is that coverage? I think your statement indicated for employers over 100, 9 out of 10 of those employers offer dental—

Ms. KORDEK. Right.



Mr. KLECZKA. Which is a surprisingly high amount, knowing full well it is an expensive thing for employers.

Mr. KORDEK. Again, many of them offer it on an employee deduction, employee voluntary basis. They—employers—do not necessarily have to pay for the coverage.

Mr. KLECZKA. So they devise the plan or contract with you folks, but it is voluntary on the part of the employees?

Ms. KORDEK. Right, and those people who want to choose to spend their health dollars can elect that option on a payroll deduction basis with the tax advantage.

Mr. KLECZKA. Dr. Zapp, have you found any extra dollars for us to pay for all this?

Dr. ZAPP. Actually, Mr. Chairman, we are not asking for extra dollars. I think in the detailed statement that we are submitting for the record, we had hoped there would be no change as relates to the current benefits program that exists today. What we wanted was low-income coverage to be extended from the children to the adults and a children's preventive program, so we were not asking for an expansion.

Mr. KLECZKA. Well, it is an expansion, because currently those folks are not being covered, and if in fact they would be provided the coverage, those are additional costs which we are not paying for today.

Dr. ZAPP. In the Medicaid program.

Mr. KLECZKA. In the universal health care program. Assuming what you are talking about is the 35 to 37 million Americans with no health care whatsoever, and if we brought them under the umbrella, I don't know if it would be akin to the Medicaid program, but with that mass of people, knowing full well they have no insurance whatsoever, dental is the last thing on the agenda. So naturally, your up-front costs are much higher there, because there is a catchup for those types of folks.

Dr. ZAPP. I don't think that we were necessarily suggesting that the 37 million of uncovered used in the medical field is transferrable into the dental field. I don't think that is the same figure at all.

Mr. KLECZKA. So you think some of those are currently getting dental coverage—not coverage, but taking care of their dental needs?

Dr. ZAPP.

Dr. ZAPP. Some of them are and I think some of them are not. I think we would like to see, as we said, the people who are currently eligible under the Medicaid program, we would like to see more education, we would like to see more of them make use of the benefits that are available to them today, but that is a program that currently is not on the books.

Mr. KLECZKA. I am missing a point here.

Yes, Dr. Dillenberg?

Dr. DILLENBERG. You cited the GAO study about \$50 billion. The package that the coalition is suggesting is a \$7 billion package. That is looking at a \$9 per person per month cost for those under 200 percent of the poverty level, which is not a significant amount of money in terms of the big picture.

Mr. KLECZKA. Versus the \$900 billion?



Dr. DILLENBERG. Yes.

Mr. KLECZKA. Ms. Kordek.

Ms. KORDEK. One other issue is for governmental programs for those in existence showing that prepaid dental can reduce dental premiums by at least 30 percent. We would encourage the use of managed or prepaid dental programs for those Federal programs in existence.

Mr. KLECZKA. In a statement from Ms. Kendall, on the last page you indicate your desire for any Federal legislation to provide for preventive oral health care benefits which will also insure Americans access to dental hygienists. Are you looking for a direct bill type of a benefit here, or are you satisfied with the current gatekeeper approach, where I am assuming the dentists would authorize any reimbursement?

Ms. KENDALL. No, they don't necessarily now in all places. In some States, there are a couple of States where there is independent practice and the billing is not through a dentist at all.

Mr. KLECZKA. So two States provide for that already?

Ms. KENDALL. Yes.

Mr. KLECZKA. Do you know which two they are?

Ms. KENDALL. Colorado and Washington.

Mr. KLECZKA. Washington State?

Ms. KENDALL. And California has that, as well, in a pilot sense. I think whatever the outcome, it should be that more people are served, that preventive services of licensed hygienists the States already assure deliver safe care to the public. They are licensed, so that has already been determined by the State, then a system should be designed to get the patient and the provider together in the most efficient cost effective way, and I don't think we should pattern it after what we have.

Mr. KLECZKA. Regardless if there is a gatekeeper provided for? Because what some of us are talking about in the medical portion of the health care dilemma is that we provide for a general practitioner to be the gatekeeper before one goes right to the specialist, and we find that today that is not the case and that is adding a lot to the medical costs of this Nation.

Ms. KENDALL. We believe it adds a lot to the dental hygiene costs at this point in time, too, and we are working with that on the State level.

Mr. KLECZKA. If we go through the dentists?

Ms. KENDALL. Yes. That is currently the case in the private dental office pretty much, 80-some percent of the delivery happens there now. That is the main place where dentistry and dental hygiene services are delivered.

Mr. KLECZKA. I have a real problem with every delivery group hanging out their own shingle. We saw that back in the State of Wisconsin when I was a State legislator working with the Medicaid program, and every provider group wanted to direct bill. Clearly, if we are about to reform the health care system and to retard some of the expenditures, we just cannot give everyone a key to the Treasury.

Ms. KENDALL. I really do not think you would need to do that. If we are looking at what are the benefits, what are the elements of the benefit package, that is a separate—

Mr. KLECZKA. The long-term benefits and even short-term benefits are great, but it is still a cost thing that we have to worry about.

Ms. KENDALL. No, I mean what are the particular services, when I say benefits, and you outline what those are. Anyone that can legally provide those should be able to provide those. If there is a gatekeeper, it should be structured in a way that it is not one that is costing more. Anyone that can legally and safely provide those services should be able to do that and bill for it. That is part of the cost of doing business. I think that politically and economically cobbles up the development of a system that is cost effective and quality.

Mr. KLECZKA. Now, does the ADA support that?

Ms. KENDALL. We disagree on that.

Dr. ZAPP. I think that is a fair statement, to say we would disagree, Mr. Chairman. [Laughter.]

Mr. KLECZKA. Thank you.

Do any of the members of the panel have any additional comments they would like to make? Dr. Dillenberg, you are chomping at the bit here.

Dr. DILLENBERG. No, not really, shy as I am. [Laughter.]

Mr. KLECZKA. You are still looking for those extra dollars.

DR. DILLENBERG. I think one of the things is the Medicaid system clearly isn't working, from our perspective, and I think there are a lot of folks that are eligible for Medicaid but they are not getting in. We have a problem with adequate numbers of providers in communities. I think the reimbursement of Medicaid dental providers is an issue that needs to be looked at, possibly the way the services are delivered, where they are delivered.

I think that the task force has some difficult complex issues to address and I think that patching up the current Medicaid system I would not see as one of the viable options for the success that we are trying to gain here, particularly from the fiscal side and getting the services, the access to care to those people at most risk. And I think whether it be children or adults, and clearly both of them need our attention, I think we have to make a paradigm shift there and I encourage the subcommittee in their efforts with it.

Mr. KLECZKA. If you think the Medicaid program should not be a model, would you support to some extent using the Medicare program as a model which has been espoused by the Chairman, Fortney Stark?

Dr. DILLENBERG. Well, there is no dental in the Medicare model, so I think I have got a problem with that. We talk about the HMO model and—

Mr. KLECZKA. That is why I like that one. [Laughter.]

No, that could be provided for, but I am saying a system which is very structured, reimbursement is controlled very tightly. In fact, doctors think—

Dr. DILLENBERG. Excuse me. If oral health is included within the framework, the structure is one issue, but I think we need to be sure that oral health is included in there. I think similarly with the HMO model that people talk about, again, oral health and dental services are optional services.

They are not an integral part of the basic benefit package which I think is the clear issue that we are looking at, that we need to make sure that dental services are there and at that point then we can look at how do we want to structure the system and how do we want to devise a delivery system for that. Because once you have the benefit package, then we have to say how do we get it to those high-risk populations that we want to serve, and I think that is going to be another issue that needs further discussion.

Mr. KLECZKA. Thank you.

Thank you all for your testimony. We will be looking for your guidance and counsel over the next months, as we formulate a plan. For those attending the hearing in the audience, let me also thank you for your kind attention.

The committee will adjourn this hearing.

[Whereupon, at 4:27 p.m., the subcommittee adjourned, to reconvene at 9:50 a.m., Thursday, April 22, 1993.]





## CONSIDERATION OF BENEFITS FOR INCLUSION IN A STANDARD HEALTH BENEFIT PACKAGE

THURSDAY, APRIL 22, 1993

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning. Today, the subcommittee continues its series of hearings on health care reform by focusing on a possible standard benefit package. We have scheduled this as a followup to our March 30th hearing in order to accommodate more than 70 organizations who requested to testify on this topic.

A number of health reform proposals would establish standard health benefits for all Americans—I like to say all residents. During the subcommittee hearing, we will continue to consider critical policy questions concerning the design and implementation of a standard benefit plan.

First is the issue of what benefits and services should be included in the package, and I am sure that each of our witnesses today will offer their views on those benefits and services that they believe should be covered.

A second item concerns who should design the benefit package. Some would suggest that some ill-defined national board or commission should be created and given the responsibility for determining which services should be covered for all residents. Others, including myself, believe that the benefits should be determined and modified, as necessary, by the Congress, which is in the end directly accountable to the citizens of the country.

A third question involves the distributional effects of moving toward a standard benefit package. Expert testimony at the March 30 hearing described in some detail the wide variations in the structure and scope of the benefits covered.

Today's hearing on a possible standard benefit package will focus on what may well be one of the most complex and controversial components of any health reform plan. I look forward to the testimony of our witnesses.

Before proceeding, I would like to suggest to the members and witnesses, we are going to attempt to hear from over 40 witnesses today. We will necessarily run a tight clock. For those witnesses

who have not had the experience of testifying before this committee often, I assure you that prepared testimony which is included in the record is considered thoroughly by staff and by members, and we are not bashful about coming back to you after the hearing when we have questions that may subsequently develop.

So this is an attempt to make sure that everybody is heard, to build a record for future legislation. The limited time is necessary to accommodate everybody, and I would appreciate as much consideration as possible on that.

At this point, I would like to welcome Mr. Thomas and recognize him for any remarks he chooses to make.

Mr. THOMAS. Thank you, Mr. Chairman. I will be brief, as well.

Obviously, whatever the standard benefits package is will determine the success of the health care program to a very great detail, and the interest is indicated by the number of people who are here. I don't want to say that this in some way resembles a beauty contest in terms of trying to present your wares in a way that makes you more attractive.

But I can tell you, from my point of view, underscoring the Chairman's position, we do have the written testimony, it is read, it is digested. You have in front of you there lights, green, yellow and red. To the degree the testimony is contained in the green section, I think your ideas are wonderful. To the degree it moves to the yellow, I am beginning to doubt them. And if you reach the red, I hope you enjoyed your stay in Washington.

Thank you very much. [Laughter.]

Chairman STARK. He's tough.

Our first panel this morning includes a most distinguished panel of physician organizations. As always, your written testimony is included. We are going to hear from Dr. Perry Lambird, who is chairman of the Council on Medical Services, in Oklahoma City, and he is representing the American Medical Association; Dr. Alan Nelson is the executive vice president of the American Society of Internal Medicine; Dr. Mack Lipkin is president of the Society for General Internal Medicine; Dr. Howard Pearson is president of the American Academy of Pediatrics; Dr. Linda Fried is a member of the Johns Hopkins Hospital staff and is representing the American Geriatrics Society—thank you for representing me, Dr. Fried; Dr. James Hoehn is president of the American Society of Plastic and Reconstruction Surgeons; and Dr. Julianna Gulya, who is a member of the American Academy of Otolaryngology.

Welcome, and why don't you lead off in the order in which I announced you. Dr. Lambird, why don't you start off.

**STATEMENT OF PERRY A. LAMBIRD, M.D., CHAIRMAN, COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION, OKLAHOMA CITY, OKLA.**

Dr. LAMBIRD. Mr. Chairman and members of the subcommittee, my name is Perry Lambird. I am a physician from Oklahoma City, Okla., and chair of the AMA's Council on Medical Service. Accompanying me is David Heidorn, of the AMA's division of federal legislation. We appreciate this opportunity to be heard.

Last week, the AMA's board of trustees approved a standard package of health care benefits that was some 3 years in develop-



ment. We believe that these should be provided to all employees and their dependents. The details of this package are included in our written testimony, and we urge the subcommittee to consider it the essential building block upon which a sensible, efficient health care system can be structured. It is a full benefits package.

While it mirrors many benefits offered in health insurance policies today, it was designed to represent contemporary medical judgment. It reflects what the American people expect from health care and it reflects what the American people expect from health care reform.

You will find physician services here and you will find the medically appropriate services of limited licensed practitioners. Preventive health is a major cornerstone, with no cost sharing. Hospice care and unlimited prescription drugs are covered. A wide range of mental health services is given the same coverage as other medical services.

In designing this package, we strove to balance what expert physicians believe should be included and what the insurance market tells us that people want from health insurance coverage. Tradeoffs are necessary.

Importantly, this is an affordable package. We worked very closely with the widely respected actuarial firm of Gordon R. Trapnell to determine its cost, and based upon the current expense of insuring employees, this package would cost, on average, approximately \$2,700 per employee, for individuals as well as family coverage, and that includes administrative costs.

With other comprehensive health system reforms, advocated by the AMA—insurance that includes community rating, tax deductibility of insurance coverage linked to the standard benefits package, medical liability reform, ERISA reform, elimination of State mandated benefits and preexisting condition limitations, and a requirement that all employees receive coverage—we believe it is possible to reduce these costs even further. We urge you to carefully consider this package.

We also urge that the subcommittee develop criteria for determining a package and offer our own experience as a model. We found the need for two levels of criteria—an initial set to determine the broad suitability of service for third-party coverage, and a second one to try and rank some of these benefits. I would like to discuss very briefly the three specific criteria.

First, the service must be essentially medical, not custodial. While we have a comprehensive package, we believe there is a pressing need to fulfill quickly the health care needs of all Americans by limiting covered services to those that prevent and treat illness.

Second, the service must be safe and clinically efficacious. There must be some mechanism established to assure that a standard benefits package will always reflect the best of medical care. We are well along the line of developing practice parameters and other tools to continue our long tradition of assuring improving the quality of care, and this expertise must be made part of the process of change.

We have asked the Clinton administration to consider establishing a National Council on Health Care Value that would be respon-

sible for establishing a Federal benefits package, and we hope that you would support that proposal.

The third major criterion was that an equally effective and less costly service is unavailable.

Mr. Chairman, in the context of guaranteeing universal health coverage, we welcome the Government's cooperation in establishing a standard benefits package. It is a difficult process. We stand ready to assist you and the subcommittee in shaping the standard benefits package that will meet the health care needs of all Americans.

Thank you, sir.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

**Statement  
of the  
American Medical Association  
to the  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives  
April 22, 1993  
Re: Standard Health Benefits Package**

Mr. Chairman and Members of the Subcommittee:

My name is Perry Lambird, MD. I am a physician from Oklahoma City, Oklahoma. I am also Chairman of the American Medical Association's Council on Medical Service. The AMA appreciates this opportunity to appear before the Subcommittee to present our views on the essential elements that should be included in a standard health benefits package.

We offer today what we believe is information with historic implications. The AMA Board of Trustees, upon recommendation of its Council on Medical Service, last week approved a new standard package of health care benefits that should be provided by all employers to employees and their dependents and be available as well through state risk pools. The package will be presented to the AMA House of Delegates in June. A description of the package accompanies this statement.

The AMA has advocated the need for a uniform, basic package of health benefits since the beginning of our involvement in health system reform. A standard benefit package is the essential building block upon which a sensible, efficient health care system can be built. It is the fulcrum upon which the success of health system reform will be balanced. If too costly and rich a set of benefits are chosen, overall health system reform may become too expensive and wasteful. Too few benefits, and the health care needs of the American people will not be met.

In determining a standard benefits package, it is necessary to strike a balance between what physicians, as experts in providing medical care, believe should be part of a standard benefits package and what the insurance market tells us people want from health insurance coverage. Necessarily there must be tradeoffs between desired coverage and the financial constraints of those who purchase insurance.

We have designed a package that reflects the typical benefits offered in many current health insurance policies today -- including the benefits available under the Federal Employees Health Benefits Program -- thereby reflecting what the American people expect in health care. You will not only find physician services here. Medically appropriate services are available from limited licensed practitioners as well. Preventive health is a major cornerstone of this package, and no cost sharing is required for preventive services. Hospice care is included, as is coverage for unlimited outpatient prescription benefits. A wide range of mental health services are given the same coverage as other medical services.

Most importantly, the package is affordable. The AMA has worked closely with the widely respected firm of Gordon R. Trapnell Consulting Actuaries, which has determined the costs of the package. Based on current costs of insuring employed individuals across America, this package would cost on average approximately \$2700 per employee for individual as well as family coverage.



With other comprehensive reforms of the health care system that the AMA and others have advocated -- insurance reform that includes community rating, tax deductibility of insurance coverage linked to the standard benefits package, medical liability reform, increased fair competition among providers and among insurers, ERISA reform, and a requirement that all employers provide insurance coverage -- we believe it is possible to reduce these costs even further. Hawaii has accomplished virtually universal health care coverage by requiring all employers to provide coverage for their employees and requiring health insurance premiums to be based on what is essentially community rating, at a cost that is below that of the health systems in Canada and Germany that are often touted as solutions to problems in the U. S. health care system.

The AMA urges the Subcommittee to consider this standard health benefits package in the context of the other steps that must be taken to ensure that all Americans have access to affordable, quality health care.

### **Criteria for Determining Suitability of Services**

The AMA firmly believes that the standard package we offer here is one that can serve as the basic building block of health system reform. We understand, however, the deliberations the Subcommittee and full Committee must undertake in order to make its own decisions in examining this issue, and offer our full assistance. We urge that careful consideration be given to the criteria used for determining a standard benefits package. We hope our own experience as well as our expertise can be helpful to the Subcommittee both now and in the future. In the Council on Medical Service's deliberations on determining the standard benefits package we offer, the need for two levels of criteria emerged.

First, we found that an initial set of criteria was necessary to determine the broad "suitability" for third-party coverage:

#### **1. The service is essentially medical, not custodial or supportive.**

The standard benefits package we have developed is fairly comprehensive in the services it provides. Yet, a standard benefits package aimed at meeting the highest needs among the widest population at a cost that is affordable to most Americans cannot include everything everyone, including physicians, may wish. The pressing need to fulfill the fundamental health care needs of all Americans is best met by limiting services covered to those that are essentially medical, to services that prevent and treat illness. The need to do this is immediate. A standard benefits package should be aimed at alleviating that need as quickly as possible.

The package we have developed includes skilled nursing facility services and hospice services, but the cost of providing for similar extended coverage that is more custodial or supportive in nature, even though such coverage may even be medically related, needs to be dealt with uniquely and not be allowed to confuse the issue of providing needed medical coverage to all Americans.

#### **2. The service is safe and clinically efficacious.**

Determining what medical service is safe and clinically efficacious is one of the key challenges facing the practice of medicine. This also will be a central challenge of the Administration and the Congress, not only at the beginning of health care reform but in the future. A standard benefits package is not static; it will be a living document, continually in need of reexamination and updating.

We can start out by structuring a package along the lines of what is provided by typical health care insurance now, as the AMA has done with this package. But as we become increasingly better able to determine the effectiveness of medical care, and medical technology and the ability of physicians to provide more effective care continues to improve, there will be an increasing need to ensure the quality and cost-effectiveness of more and more of the specific services provided under a standard benefits package.

The medical profession is already well along in its efforts toward the development of practice parameters, aimed at providing physicians with the best and latest information about the effectiveness of specific medical treatments. Developed by the profession, practice parameters continue the medical profession's long tradition of educating itself and establishing mechanisms to assure quality medical care. The profession's work in this area must be taken into consideration as a mechanism for the continual reexamination of a standard benefits package is put into place.

To provide for such a mechanism, the AMA has recommended to the Clinton Administration that a National Council on Health Care Value be established. One of its key functions would be the establishment of a federal standard benefits package, determined through the consensus of those the AMA hopes can be involved in such a council -- practicing physicians, other providers, government, insurers, employers, and others. We urge the Subcommittee to consider our proposal. A standard benefits package created under the auspices of the federal government must be determined based on the needs and views of all those involved in health care, but physicians are uniquely situated to provide the expertise needed to construct and continually examine such a package. Because of their expertise, physicians must be made an integral part of such a permanent process.

### **3. An equally effective and less costly service is unavailable.**

We urge the Subcommittee to consider carefully the way we have phrased this criterion. Physicians' first concern in providing medical care is effectiveness. Medical care cannot be determined through a cost/benefit analysis. As physicians, we cannot allow medical care to be measured on a continuum of cost measured against effectiveness. Physicians have to know, above all else, whether a service is effective. Then we may allow ourselves the question of whether or not a less costly, but equally effective service is available. That is our professional responsibility to our patients. We know our patients do not want medical decisions made in any other way. Increased development and dissemination of practice parameters will help us make these decisions.

Yet, other changes in our health system must be brought about if we are to be freed to make truly cost-effective decisions in the best interests of our patients. Now, too many of our decisions are based on warding off potential lawsuits. Defensive medicine, it has been estimated, adds anywhere from between \$4 billion to \$25 billion annually to the cost of health care. The knowledge that there are reasonable limits on medical liability will help physicians make decisions that are truly in the best interests of our patients.

### **Criteria for Ranking Services**

Once a determination of "suitability" is made, there is a further need to determine the relative value of services to be included in a standard benefits package. We have determined that the following criteria should be used in conducting such a "ranking." These criteria are not totally new. Each are important and are listed without regard to their order of priority:

- The increase in quality-adjusted life years per dollars spent on the service.
- The probability of death without provision of the services.
- The probability of improving organ or patient function without provision of the service.
- The probability of achieving an asymptomatic state without provision of the service.
- The probability of relieving pain without provision of the service.

- The probability of achieving a disease-free state without provision of the service.
- The degree of consistency with applicable practice parameters or guidelines.
- The extent, if any, to which costs of the service are offset by resulting subsequent savings in costs of morbidity and mortality over the insured group.
- Average cost per occurrence for use of the service.
- Frequency of need for the service across the population covered.
- The degree to which need for the service is predictable.
- Annual cost of insuring the service per covered person in a community-rated system.

Obviously, making these determinations is a difficult process. The ultimate decisions are largely subjective in nature. Depending on the type or specificity of the service being considered for coverage, some of these criteria cannot be applied rigorously. We are convinced, however, that, when considered as a whole, these criteria will sharpen the decision-making choices of which services to include in a standard health benefits package.

### **Conclusion**

In the context of comprehensive health system reform, physicians welcome the government's cooperation in helping establish a standard benefits package and guaranteeing universal coverage. The decisions are difficult. Physicians and hospitals for too long have been, through default, the ad hoc authority for making similar decisions at emergency department doors of how to provide typically unreimbursed care to the uninsured. For those who are insured, insurance companies have far too much freedom to effectively limit coverage of needed health care services, often after the services have been provided. This situation cannot continue.

The AMA applauds the Subcommittee's attention to a standard benefits package. We stand ready to assist the Subcommittee as it makes the difficult decisions necessary to shape a standard benefits package that not only will meet the health care needs of the American people, but help manage the limitations inherent in meeting those needs.



Chairman STARK. Dr. Nelson.

**STATEMENT OF ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE**

Dr. NELSON. Thank you, sir.

A basic benefits package must be considered in the overall context of health care reform, and my remarks today will focus on those components and characteristics of clinically effective services that should be included in the basic benefits package of all payers, both public and private.

ASIM believes that all health care plans, both public and private, should include in their basic benefits package coverage for clinically effective preventive services that include certain key components that have certain identifiable characteristics which are outlined in our statement.

For Medicare, we support inclusion of an expanded set of benefits, including periodic health evaluations, immunizations, colorectal cancer screening, smoking cessation counseling and other clinically effective preventive services.

For Medicaid or its replacement, we support adoption of the uniform basic benefits package with enhanced primary and preventive care services which enrollees may receive either through a public program or purchase with Federal subsidies through an accountable health plan.

Generally, ASIM believes preventive services for which coverage is mandated should have the following characteristics: They have been demonstrated by scientific criteria to be clinically effective; they are tailored to and provided with a frequency determined by age and gender; and they are modified as new scientific evidence concerning effectiveness becomes available.

In addition to those preventive services that should be available to all persons, there are other services that are indicated only for persons assessed to be at risk for particular conditions. Risk factors that justify additional preventive services may include personal or family history of disease, personal behavior or other unique individual characteristics.

A minimum benefit package should also provide for those clinically effective screening tests and procedures and risk reduction interventions that are tailored to individual need, based on a professional assessment of individual risk factors.

One place to start in deciding what preventive services should be included in the basic benefit package would be the 1989 report of the U.S. Preventive Services Task Force on the effectiveness of 169 medical treatments. This task force brought together physicians, researchers, and health policy experts under the auspices of the Health and Human Services Department to review, debate, and critique literature and scientific studies on a variety of interventions on 60 different illnesses and conditions.

Among the illnesses addressed by the guide are cardiovascular and infectious diseases, cancers, injuries, alcohol and drug abuse, prenatal disorders, and musculoskeletal conditions.

One issue I would especially like to emphasize is that of coverage of routine physical exams or what are sometimes called periodic health evaluations. ASIM believes that a periodic health status

evaluation is an important tool of preventive medicine and, therefore, urges that some coverage be provided for such examinations.

Historically, routine adult periodic health evaluations and other preventive services have not been covered by most insurers. Low payments for primary care are related to the longstanding lack of coverage for primary care and preventive services.

In addition, high deductibles have effectively eliminated coverage of primary care services, because patients rarely see the primary care physician often enough to meet the deductible. Furthermore, high deductibles for primary care have acted as a disincentive for patients to obtain services from primary care physicians.

To encourage improved access to primary care, ASIM believes that, as a condition of being certified as an accountable health plan, all plans should be required to establish a lower deductible for periodic health evaluations and other clinically effective preventive and primary care services.

ASIM has also endorsed the establishment of a national health care board which would have among its responsibilities the creation and revision of the standard health benefit package. ASIM believes this would be an appropriate role for such a board, if physicians who provide primary care, including internists, are given a prominent place on the board.

To summarize our recommendations, ASIM urges Congress to:

One, expand Medicare coverage for primary care and clinically effective preventive services; two, require all plans, both public and private, to cover clinically effective preventive services that meets the components and characteristics specified in the joint statement of ASIM, the ACP, and the ACPM; three, require all private plans, as a condition of being certified as an accountable health plan, to provide coverage for clinically effective preventive services that meet the specified components and characteristics; four, review the recommendations of the U.S. Preventive Services Task Force in deciding on the specific preventive services that should be included; five, require all accountable health plans to have a lower deductible for primary care and clinically effective preventive services than for other physician services; six, consider the recommendations of the Health Policy Agenda for the American People in determining the specific basic benefits to be required of AHP's; seven, require all accountable health plans to provide coverage for periodic health evaluations by physicians; eight, require Medicaid or any new public program to replace Medicaid to provide uniform, basic benefits to all enrollees and consider the recommendations of the HPA's ad hoc committee on Medicaid; nine, make changes in the Tax Code to encourage the availability of long-term care insurance, mandate improved consumer protections, enact "asset protection" legislation to protect individuals from having to "spend down" their assets in order to qualify for long-term care benefits, and provide for expansion of Medicare to cover such services once an individual reaches a certain out-of-pocket expenditure threshold; and ten, establish a national board with prominent representation by internists to decide on the specific conditions of coverage and services to be covered, once broad categories of benefits are established by Congress.

Thank you, Mr. Chairman.

[The prepared statement follows:]



**TESTIMONY OF ALAN R. NELSON, M.D.**  
**American Society of Internal Medicine**

Good morning, Mr. Chairman and members of the subcommittee. My name is Dr. Alan R. Nelson and I am Executive Vice President of the American Society of Internal Medicine. ASIM is the fourth largest adult primary care medical specialty society in the United States, representing 28,000 practicing physicians in general internal medicine and internal medicine subspecialties. We were among the first physician organizations to endorse comprehensive health care reform and appreciate the opportunity to share with you today our views on the composition of a basic health care benefits package to be covered under a new health care system.

A basic benefits package must be considered in the overall context of health care reform. My remarks today will be based on the assumption that reform will follow most of the tenets of managed competition and references are made throughout this statement to elements of that reform approach. ASIM believes there are three major areas in need of attention in designing a benefits package under health care reform. The first has to do with the Medicare program and its benefit structure, the second with the benefits to be offered by private insurers through accountable health plans (AHPs) and the third with benefits provided under Medicaid (or a new federal program that may be proposed to replace Medicaid). ASIM has offered its own principles for reform of the health care system based on managed competition. Our principles include support for:

- ◆ a pluralistic system of health insurance plans that must meet certain defined standards to qualify as accountable health plans (AHPs). Such standards would include offering a basic benefits package to insureds that promotes primary and preventive care and contains no preexisting condition exclusions or experience rating;
- ◆ preemption of state mandates, once insurers qualify as accountable health plans offering the basic benefits package. This would only be logical as many of the state mandates will apply to services subsequently covered under the uniform benefits package and state mandates that go beyond the federally-defined benefits package would drive up the costs of the program;
- ◆ an employer mandate to provide employees with insurance coverage. Insurance coverage contributions would be tax deductible to the employer and employee up to a cap set at a level striking an appropriate balance between cost-effective selections of health plans and maintenance of a competitive position for a variety of health plan options;
- ◆ reform of the Medicaid program or its replacement with a public health program to assure that persons unable to get subsidized health care coverage through an employer will still have access to care. Such access could be provided either through enrollment in a public program offering the basic benefits package or through federal subsidies enabling individuals to purchase coverage through an AHP. Benefits and eligibility under the public program must be uniform to avoid variations from state to state;
- ◆ retention of Medicare as a separate program but with enhanced coverage of primary and preventive care services.

Within this overall context, the remainder of my testimony will address:

- ◆ recommended additions to Medicare benefits to provide better coverage of preventive and primary care services.
- ◆ components and characteristics of "clinically effective" preventive services that should be included in the basic benefits packages of all payers, both public and private.
- ◆ specific benefits that should be included in the basic benefits packages of accountable health plans (AHPs).
- ◆ improvements in benefits under Medicaid (or under a new program to replace Medicaid).
- ◆ expanding availability of long-term care insurance.
- ◆ who should decide on the basic benefits package.



### Expanding Medicare Benefits for Primary Care and Preventive Services

If Medicare is to remain a separate program, as ASIM believes it should, the services covered by Medicare should be enhanced to encompass to a greater extent than it does now the kind of evaluation and management and preventive services typically required by elderly patients. In a recently released paper titled Rebuilding Primary Care: A Blueprint for the Future, ASIM details the many challenges facing physicians who provide primary care in today's health care system and offers 44 specific recommendations for improving the regulatory, reimbursement and training environment of primary care. In that report, ASIM proposes that Medicare coverage be expanded to include those preventive and screening services provided primarily by physicians who provide primary care, including coverage for:

- ◆ periodic health evaluations
- ◆ immunizations
- ◆ colorectal cancer screening
- ◆ smoking cessation counselling
- ◆ other clinically effective preventive services.

As the committee knows, Medicare currently pays only for services that are needed to diagnose or treat a medical condition or symptom. Preventive services are generally excluded from coverage. Because primary care physicians are the principal providers of preventive services to Medicare patients, the current exclusion disproportionately hurts primary care and denies patients access to needed – and cost effective – services. I would note in particular that coverage of colorectal screening is also strongly supported by ASIM members who subspecialize in gastroenterology, and their professional subspecialty societies, including the American College of Gastroenterology.

### Components and Characteristics of Preventive Services

ASIM believes that expansion of benefits for clinically effective services must not be limited to Medicare. Rather, all plans – both public and private – should include in their basic benefit packages coverage for clinically effective preventive services that include certain key components and that have certain identifiable characteristics. In a joint policy statement with the American College of Preventive Medicine and American College of Physicians, ASIM recently set out what we believe should be the guiding principles for coverage of preventive services under health care reform. We and these other physician organizations believe that:

"prevention should be a fundamental component of health care reform. Effective preventive services improve the quality of life and prolong life. The purposes of preventive services are to prevent the development of disease, to enable early detection of disease and to minimize the complications resulting from disease.

Clinical preventive services provided to infants and children, adolescents, pregnant women, and adults, all include three components:

- **Screening**, including history and risk assessment, physical examination and laboratory tests.
- **Counseling**, to explain the relationship between risk factors and health and to assist patients in acquiring the knowledge, motivation and skills to adopt and maintain healthful behaviors.
- **Immunizations**, to prevent infectious diseases.

Preventive services for which coverage is mandated should have the following characteristics:

- They have been demonstrated by scientific criteria to be clinically effective;
- They are tailored to and provided with a frequency determined by age and gender;
- They are modified as new scientific evidence concerning effectiveness becomes available.

In addition to those preventive services that should be available to all persons, there are other services that are indicated only for persons assessed to be at risk for particular conditions. Risk factors that justify additional preventive services may include personal or family history of disease, personal behavior, or other unique individual characteristics. A minimum benefit package should also provide for those clinically effective screening tests, procedures, and risk reduction interventions that are tailored to individual need, based on a professional assessment of individual risk factors.<sup>6</sup>

Examples of individualized preventive services include an altered schedule of physical exams and mammograms for persons with familial histories of breast cancer and scheduled sigmoidoscopy or colonoscopy for persons with familial or personal histories of colon polyps. These services should be considered individually for inclusion in a minimum benefits package.

One place to start in deciding what preventive services should be included in a basic benefits package would be the 1989 report of the U. S. Preventive Services Task Force on the effectiveness of 169 medical treatments.<sup>7</sup> This task force brought together physicians, academic researchers and health policy experts under the auspices of the Department of Health and Human Services to review, debate and critique literature and scientific studies on a variety of interventions on 60 different illnesses and conditions. The process took over four years and resulted in an extensive guide, with supporting documentation, to recommended courses of preventive care. Among the illnesses addressed by the guide are cardiovascular and infectious diseases, cancers, injuries, alcohol and drug abuse, prenatal disorders and musculoskeletal conditions.

#### Benefits That Should Be Covered By All Accountable Health Plans

##### *Mandating Lower Deductibles for Primary Care and Preventive Services*

Historically, routine annual periodic health evaluations and other preventive services have not been covered by most insurers. Low payments for primary care are related to the longstanding lack of coverage for primary care and preventive services. In addition, high deductibles have effectively eliminated coverage of primary care services because patients rarely see the primary care physician often enough to meet the deductible. Furthermore, high deductibles for primary care have acted as a disincentive for patients to obtain services from primary care physicians. To encourage improved access to primary care, ASIM believes that as a condition of being certified as an AHP, all plans should be required to establish a lower deductible for periodic health evaluations and other clinically effective preventive and primary care services than for other physician services.

##### *Specific Benefits To Be Required AHPs*

As a starting point for creation of a basic benefits package to be offered by AHPs, Congress should review the work of the Health Policy Agenda for the American People. A coalition of over 172 health care, business, consumer and government groups, this group was established in 1982 to devise an overall plan for reform of the U. S. health care system. The HPA's final recommendations were published in 1987 and covered issues ranging from planning and delivery of health care services, broadening access to care, ensuring quality of care to designing a cost-effective payment system.<sup>8</sup>

The HPA benefits package was meant to serve as a non-mandatory guide for businesses, consumers and insurers when developing or choosing health coverage and was intended to be flexible so that it could be altered to meet the particular needs of different groups in the population. However, given that the HPA package represents the consensus of a wide array of important participants in the health care system, its basic package would be a reasonable basis from which to begin developing a package for health care reform. A list of the services comprising the HPA's basic and expanded packages is provided with this statement as an attachment but generally include:

- ◆ physicians' services;
- ◆ inpatient and outpatient hospital services;
- ◆ laboratory and x-ray services;
- ◆ prescription drugs;

- ◆ institutional care for the elderly and the physically or mentally disabled;
- ◆ dental services;
- ◆ and other medically necessary professional services.

The HPA benefits are broken into three categories: a) prevention and early identification, b) acute care and c) chronic care. These benefits are further defined in two levels: those considered essential services and a more extensive package of benefits that includes "desirable benefits" that are "less compelling in a cost/benefit trade off." Most of the benefits referenced in the HPA basic and extended packages are in some fashion offered today by most federally qualified health maintenance organizations. While the basic benefits identified by the HPA would be most appropriate for inclusion in a package, it is possible the extended benefits package proposed by the HPA might also be appropriate for incorporation. However, that decision should be based on the financial constraints facing the system including increased costs of reform to employers and the U. S. treasury.

When it was first issued, the cost of the HPA basic benefit package was estimated at a range from \$1,300 to \$2,800. The cost of the enhanced package was estimated to be between \$1,500 and \$3,550. Costs were based on actuarial calculations of coverage costs for different insured populations and practice areas. Obviously, these estimates, having been done in 1987, need to be updated. After these costs are ascertained, ASIM believes a tax cap on the deductibility of the employers contribution to the purchase of health insurance should be established but at a level that allows for purchase of the HPA's basic benefits package and whatever additional services may be considered for inclusion in the mandated benefit package. Those benefits that go beyond the HPA recommendations may need to be looked at more critically from a cost and medical necessity standpoint. ASIM recognizes that valid arguments can be made as to why certain additional services should be included or others excluded, however, we believe the Health Policy Agenda plan represents the best effort to date by a broad group of health, consumer and business organizations to reach a consensus on what should be included in a health coverage package.

ASIM believes that the specific "preventive and early identification services" that the HPA recommends for inclusion in a basic benefits package should be refined based on the key components and characteristics that were described earlier in this statements and should reflect the recommendations of the U. S. Preventive Services Task Force.

ASIM's position on the HPA benefits package as originally proposed does differ slightly on two counts. The Health Policy Agenda indicated that routine physicals need not be covered under a basic health care benefits package. As noted earlier, ASIM believes that a periodic health status evaluation is an important tool of preventive medicine and, therefore, urges that some coverage be provided for physical examinations. In addition, ASIM believes that the services provided under any benefits package should be done under the direction of physicians. Many allied health professionals play a valid and important role in providing these services. However, these services should not be provided without the oversight and instruction of the medical community. Therefore, if the package is adopted, it should include a preface that stipulates the role of the physician in determining the actual need for these services.

Finally, other specific services ASIM believes should be included in a basic benefits package are: appropriate coverage of physician case management services, professional services provided in observation units of hospitals, delivery of home infusion IV therapy, telephone consultations with family members and patients, screening for colorectal cancer, interpretation of diagnostic tests (e.g. electrocardiograms), administration of injectable drugs, and other physician-administered laboratory services, such as specimen collection.

#### Benefits under Medicaid or a New Public Program

We understand that consideration is being given by the administration to incorporation of the Medicaid program into the broader health care system. Whether Medicaid is retained and improved or some new federal public health program is developed to ensure access to health care for those outside the employer-based system, ASIM believes that such a program must adhere to a federally mandated benefit package to avoid the inconsistencies and variation that have plagued the current Medicaid program.

Again, ASIM would draw the attention of this committee to the recommendations of a separate task force appointed by the Health Policy Agenda for the American People and chaired by New



York Assemblyman James Tallon to develop a basic benefits package and accompanying cost projections for the Medicaid program. Among the services proposed for coverage under Medicaid by that task force were: physicians services, inpatient and outpatient hospital services, lab and x-ray services, prescription drugs, institutional care for the elderly and physically/mentally disabled, home health care plus family planning, personal care services, and Early Periodic Screening Diagnosis and Treatment (EPSDT). Using projections devised by then-Harvard University professor Kenneth Thorpe, PhD, the task force estimated the costs of a uniform benefits package for Medicaid using two state benefit plans (Minnesota's and Washington's) as models. Minnesota was chosen as a plan typical of a comprehensive set of services most appropriate for Medicaid patients. Washington's plan was selected as a more modest approach to a Medicaid benefits package. For example, while Minnesota does not cover certain services and Washington does, Minnesota places no limits on physician visits, home health care services or the services of nurse midwives, unlike the state of Washington. The reported costs of uniform Medicaid packages under these two approaches were \$21.5 billion for the services offered by Minnesota and \$6.5 billion for the package offered by Washington state. Of course, as was the case with the HPA benefits package, the cost projections for this Medicaid package were made some years ago and would need to be revised to reflect more accurately the costs of the plans today.

ASIM understands that the President's Task Force on Health Care Reform is considering phasing out Medicaid. Instead, the federal government would subsidize the enrollment of low-income Americans in the same AHPs as all other Americans. If this approach is adopted by Congress, the HPA's recommendations on a basic benefits package for Medicaid should be considered in the interim until all low-income Americans can be enrolled in an AHP.

#### Long Term Care Benefits

I will address long term care separately from the various issues just discussed. ASIM strongly supports ensuring peoples' access to long term care through both the public and private sectors. We believe financing for long term care should come from both an expansion of Medicare coverage, once an individual expends a "reasonable" dollar amount for such care or stays in a nursing home for one year, and from changes in the tax code to encourage the development and purchase of long term care insurance. ASIM supports "asset protection" legislation to protect individuals from having to "spend down" their assets in order to qualify for long-term care benefits. ASIM also supports changes in federal and state regulations that enhance consumer protections in the long term care insurance market that would assure appropriate standards of coverage, disclosure, protections against sales abuses, regulation of renewal and cancellation, requirements for sufficient reserves and development of benefit/premium ratios. Long term care services should include hospital care, nursing home and hospice care, home care, respite and day care. The primarily social aspects of long term care – custodial or institutional care and outpatient personal care – should be financed separately from other health care services. Because of the extraordinary costs of covering long-term care, ASIM believes that approaches to increase the availability and quality of long-term care insurance, with an expansion of Medicare benefits after a certain dollar threshold has been reached, should be tried before mandating that all plans include long-term care.

#### Basic Benefits: Who Decides?

Although Congress should mandate the broad categories of services to be included in a basic benefits package, decisions will still need to be made on the conditions of coverage and the specific services to be included within those broad categories. ASIM has endorsed the establishment of a national health care board which would have among its responsibilities the creation and revision of the standard health benefits package. ASIM believes this would be an appropriate role for such a board if physicians who provide primary care services, including internists, are given a prominent place on the board. As those most closely involved with the total health management of patients, internists and other primary care physicians are in the best position to understand and discern what services are likely to benefit their patients. It would make no more sense to exclude internists from development of the benefits package than it would to exclude educators from development of school curricula. ASIM also strongly urges that the Secretary of Health and Human Services be required to report annually to Congress on the cost-effectiveness and desirability of providing coverage for additional preventive health care benefits in any federally-defined basic benefit package.

In conclusion, ASIM urges Congress to:

- (1) expand Medicare coverage for primary care and clinically effective preventive services;

- (2) require all plans, both public and private, to cover clinically effective preventive services that meet the components and characteristics specified in the joint statement of ASIM, the ACP and the ACPM;
- (3) require all private plans, as a condition of being certified as an AHP, to provide coverage for clinically effective preventive services that meet the specified components and characteristics
- (4) review the recommendations of the U. S. Preventive Services Task Force in deciding on the specific preventive services that should be included in the basic benefits package;
- (5) require all AHPs to have a lower deductible for primary care and clinically effective preventive services than for other physician services;
- (6) consider the recommendations of the Health Policy Agenda for the American People (HPA) in determining the specific basic benefits package to be required of AHPs;
- (7) require all AHPs to provide coverage for periodic health evaluations (history and physician examinations) by physicians;
- (8) require Medicaid – or any new public program to replace Medicaid – to provide uniform, basic benefits to all enrollees and consider the recommendations of the HPA's Ad Hoc Committee on Medicaid in determining the specific benefits to be included;
- (9) make changes in the tax code to encourage the availability of long-term care insurance, mandate improved consumer protections, enact "asset protection" legislation to protect individuals from having to "spend down" their assets in order to qualify for long-term care benefits, and provide for expansion of Medicare to cover such services once an individual reaches a certain out-of-pocket expenditure threshold;
- (10) establish a national board with prominent representation by internists to decide on the specific conditions of coverage and services to be covered once broad categories of benefits are established by Congress.

Thank you, Mr. Chairman and members of the committee, for giving ASIM this opportunity to share with you our views on this aspect of health care reform.

#### **Endnotes**

<sup>1</sup> Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions, Report of the U. S. Preventive Services Task Force, 1989.

<sup>2</sup> The Health Policy Agenda for the American People, ISBN 0-89970-229-5, 1987

**BASIC BENEFITS PACKAGE**

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**CATEGORY A SERVICES: Prevention and Early Identification****I. Maternal and Child Care**

1. Medical examination of mother before birth of child (prenatal)
2. Medical examination of mother after birth (postnatal)
3. Health supervision of children by physician
  - from birth until age 1: three visits
  - ages 1 to 2: two visits
  - ages 2 to 6: visit once a year
  - ages 7 to 18: every other year

**II. Dental Care**

1. Annual diagnostic examination and prophylaxis (cleaning)
2. Bite-wing x-rays
3. Fluoride application
4. Emergency palliative treatment

**III. Immunizations**

Immunizations at appropriate ages that are health and cost effective. (These should be derived from guidelines from Project Insure and from the American Academy of Pediatrics.)

**IV. Medical Examinations**

Procedures designed for early identification of potentially serious problems.

- Under age 40: once every five years
- Ages 40 to 49: once every three years
- Age 50 and after: once a year

Sources used to determine what tests should be covered include Project Insure and the Report of Canadian Periodic Health Examination Task Force – 1984 Update.



**CATEGORY B SERVICES: Treatment of Physical and Mental Illness (Acute Care)****I. Diagnostic and Treatment Services in the Office or Other Out-of-Hospital Setting**

1. Diagnostic services by physician, including initial consultation and second opinion initiated by patient or physician
2. Medical or surgical treatment of illness or injury
3. X-ray and lab services
4. Mental health therapy by licensed and/or certified physician or other appropriate professionals:
  - Assessment and diagnosis
  - Treatment up to 50 visits per calendar year
5. Substance abuse (drugs and alcohol) treatment by licensed and/or certified practitioners
6. Radiation and chemotherapy
7. Physical, occupational and speech therapy prescribed by a physician

NOTE: An established procedure for appropriateness review does not currently exist for services administered in the office or other out-of-hospital setting. However, the delivery of these services should be subject to review, should appropriate review systems be developed in the future.

**II. Emergency and Hospital Outpatient Services**

1. Physician services\*
  2. Operating room and supplies/equipment\*
  3. Emergency room and supplies/equipment\*
  4. Facilities charge\*
  5. Diagnostic services, including x-ray and lab\*
  6. Physician prescribed outpatient physical, occupational and speech therapy\*
  7. Radiation and chemotherapy\*
  8. Mental health services:\*
    - Assessment and diagnosis
    - Treatment, up to 50 visits per calendar year
- \* Subject to appropriateness review.

Category B Services (Cont'd.)III. Inpatient Care – Hospital and Rehabilitation Facility Services for Physical and Mental Illness

1. Semi-private room and board, including related basic services\*
  2. Diagnostic services\*\*
  3. Physician visits and services, including surgery\*\*\*
  4. Physical/occupational/speech therapy\*\*\*\*
  5. Radiation and chemotherapy\*\*\*\*\*
  6. Rehabilitation unit charges\*\*\*
  7. Medication/blood/biologicals/supplies/appliances/equipment
  8. Operating/delivery/recovery room charges
  9. Substance abuse: detoxification only, including one readmission per calendar year
  10. Mental health: professional visits and related services, 30 days per calendar year.\*\*\*\*\*
- \* Subject to admission review; pre-certification will be used selectively along with specified second opinions.
- \*\* Diagnostic services subject to admission review; pre-admission testing wherever practical.
- \*\*\* Frequency of visits subject to external appropriateness review.
- \*\*\*\* Only covered where these services cannot be provided on an outpatient basis.
- \*\*\*\*\* Admission subject to pre-certification; outpatient services are encouraged.

IV. Hospice Care – Home Setting

1. Intermittent nursing\*
  2. Continuous nursing (on a 24-hour basis)\*\*
  3. Physician visits\*\*\*
  4. Oxygen/blood/supplies/medications as prescribed
- \* Subject to physician approval.
- \*\* Frequency subject to review/case management.

Category B Services (Cont'd.)V. Home Care – Home Health Care – Short Term\*

(See Category C services for chronic care)

1. Skilled nursing care – up to 30 visits
2. Physician visits
3. Medical equipment and biologicals
4. High technology services
5. Physical, occupational and speech therapy
6. Medications
7. Durable medical equipment

\* Home health care is recommended as an alternative to hospitalization wherever feasible given physical, mental and environmental circumstances. All home care is subject to formal, written treatment plan prepared by physician. Length of treatment and frequency of visits based on diagnosis and subject to utilization review.

VI. Skilled Nursing Facility (SNF) – Short Term\*

1. Room and board – up to 45 days
2. Skilled nursing services – up to 45 days
3. Physician visits\*\*
4. Medical equipment and supplies
5. Physical, occupational and speech therapy

\* SNF is to be used as a substitute for hospitalization when appropriate. Admission is to be based on diagnosis, prognosis and formal written treatment plan.

\*\* Subject to review.



**CATEGORY C SERVICES: Chronic Care****i. Home Care -- Long Term\***

1. Skilled nursing services up to 90 visits\*\*

2. Physician visits\*\*\*

3. Medical equipment and supplies

\* The home setting is the generally preferred site for chronic care.

\*\* Subject to appropriateness review and used as offset to hospitalization.

\*\*\* Subject to appropriateness review.

**ii. Skilled Nursing Facility\***

1. Room and board up to 90 days\*\*

2. Skilled nursing services\*\*\*

3. Physician visits\*\*\*

4. Medical equipment and supplies

\* The home setting is the preferred site for chronic care.

\*\* Used as an offset to hospitalization and where home care is not feasible.

\*\*\* Subject to appropriateness review.

## APPENDIX B

## EXPANDED PACKAGE: Basic Plus Additional Desirable Benefits†

## CATEGORY A SERVICES: Prevention and Early Identification

I. Maternal and Child Care

1. Medical examination of mother before birth of child (prenatal)
2. Medical examination of mother after birth (postnatal)
3. Health supervision of children by physician
  - from birth until age 1: *six* visits
  - age 1 to 3: *three visits per year*
  - ages 3 to 6: *two visits per year*
  - ages 7 to 18: *one visit per year*

II. Dental Care

1. **Diagnostic**
  - **Semi-annual examination and prophylaxis (cleaning)**
  - Bite-wing x-rays
  - **Tri-ennial full mouth x-rays**
  - Fluoride application
  - Emergency palliative treatment
2. **Preventive and Restorative**
  - **Space maintainers and sealants**
  - **Simple restorative work – fillings of amalgam, resin (composite or acrylic)**
  - **Endodontics (root canals) including anesthesia**
  - **Extractions**
3. **Major Restorative**
  - **Crowns, inlays, onlays**
  - **Prosthodontics (dentures and bridges) – replacement no more often than once every five years**

**NOTE: The following exclusions: Adult orthodontics; Cosmetic surgery; Periodontics; Treatment for congenital anomalies; and Temporomandibular joint dysfunction**

† Differences or additions to the basic package are in bold italics.

Category A Services (Cont'd.)III. Immunizations

Immunizations at appropriate ages that are health and cost effective. (These should be derived from guidelines from Project Insure and from the American Academy of Pediatrics.)

IV. Medical Examinations

1. Procedures designed for early identification of potentially serious problems.

- Under age 40: once every five years
- Ages 40-49: once every three years
- Age 50 and after: once a year

Sources used to determine what tests should be covered include Project Insure and the Report of Canadian Periodic Health Examination Task Force – 1984 Update.

2. *Health risk factor appraisals (identify risk factors, for example, for diabetes, hypertension etc.).*

V. Risk Reduction Programs

1. *Smoking cessation*
2. *Stress management*
3. *Weight reduction and control*
4. *Nutrition*
5. *High blood pressure control*
6. *Alcohol and other substance abuse*
7. *Other (e.g. safety, fitness)*



**CATEGORY B SERVICES: Treatment of Physical and Mental Illness (Acute Care)****I. Diagnostic and Treatment Services in the Office or Other Out-of-Hospital Setting**

1. Diagnostic services by physician, including initial consultation and second opinion initiated by patient or physician
  2. Medical or surgical treatment of illness or injury
  3. X-ray and lab services
  4. Mental health therapy by licensed and/or certified physician or other appropriate professionals:
    - Assessment and diagnosis
    - Treatment up to 50 visits per calendar year
  5. Substance abuse (drugs and alcohol) treatment by licensed and/or certified practitioners
  6. Radiation and chemotherapy
  7. Physical, occupational and speech therapy prescribed by a physician
  8. *Prescription medication*
  9. *Medically necessary ambulance service*
  10. *Restorative and prosthodontic dental care\**
- \* *Adult orthodontics are excluded along with replacement of bridges, crowns or dentures in less than 5 years.*

**NOTE:** An established procedure for appropriateness review does not currently exist for services administered in the office or other out-of-hospital setting. However, the delivery of these service should be subject to review, should appropriate review systems be developed in the future.

**II. Emergency and Hospital Outpatient Services**

1. Physician services\*
  2. Operating room and supplies/equipment\*
  3. Emergency room and supplies/equipment\*
  4. Facilities charge\*
- \* Subject to appropriateness review

5. Diagnostic services, including x-ray and lab\*
6. Physician prescribed outpatient physical, occupational and speech therapy\*
7. Radiation and chemotherapy\*
8. Mental health services:\*
  - Assessment and diagnosis
  - Treatment, up to 100 visits per calendar year
9. Prescription medication\*
10. Medically necessary ambulance service\*
  - \* Subject to appropriateness review

III. Inpatient Care – Hospital and Rehabilitation Facility Services for Physical and Mental Illness

1. Semi-private room and board, including related basic services\*
  2. Diagnostic services\*\*
  3. Physician visits and services, including surgery\*\*\*
  4. Physical/occupational/speech therapy\*\*\*\*
  5. Radiation and chemotherapy\*\*\*\*
  6. Rehabilitation unit charges\*\*\*
  7. Medication/blood/biologicals/supplies/appliances/equipment
  8. Operating/delivery/recovery room charges
- \* Subject to admission review; pre-certification will be used selectively along with specified second opinions.
- \*\* Diagnostic services subject to admission review; pre-admission testing wherever practical.
- \*\*\* Frequency of visits subject to external appropriateness review.
- \*\*\*\*Only covered where these services cannot be provided on an outpatient basis.

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9. Substance abuse: detoxification only, including one readmission per calendar year
10. Mental health: professional visits and related services, **60 days per calendar year.\*\*\*\*\***

\*\*\*\* Admission subject to pre-certification; outpatient services are encouraged.

IV. Hospice Care – Institutional and Home Setting

1. **Room and board (Inpatient only)**
2. Intermittent nursing\*
3. Continuous nursing (on a 24-hour basis)\*\*
4. Physician visits\*\*\*
5. Oxygen/blood/supplies/medications as prescribed
6. **Family Counseling \*\*\***

\* Subject to physician approval

\*\* Frequency subject to review/case management

V. Home Care – Home Health Care – Short Term\*

(See Category C services for chronic care)

1. Skilled nursing care – up to 30 visits
2. Physician visits
3. Medical equipment and biologicals
4. High technology services
5. Physical, occupational and speech therapy
6. Medications

\* Home health care is recommended as an alternative to hospitalization wherever feasible given physical, mental, and environmental circumstances. All home care is subject to formal, written treatment plan prepared by physician. Length of treatment and frequency of visits based on diagnosis and subject to utilization review.

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7. Durable medical equipment
8. *Prescription medication*
9. *Mental health counseling – patient and family*

VI. Skilled Nursing Facility (NSF) – Short Term\*

1. Room and board – *up to 60 days*
2. Skilled nursing services – *up to 60 days*
3. Physician visits\*\*
4. Medical equipment and supplies
5. Physical, occupational and speech therapy

\* NSF is to be used as a substitute for hospitalization when appropriate. Admission is to be based on diagnosis, prognosis and formal written treatment plan.

\*\* Subject to review.

**CATEGORY C SERVICES: Chronic Care****I. Home Care – Long Term\***

1. Skilled nursing services up to 90 visits\*\*
2. Physician visits\*\*\*
3. Medical equipment and supplies
4. *Prescription medication*
5. *Mental health counseling\*\*\**

\* The home setting is the generally preferred site for chronic care.

\*\* Subject to appropriateness review and used as offset to hospitalization.

\*\*\* Subject to appropriateness review.

**II. Skilled Nursing Facility\***

1. Room and board up to 90 days\*\*
2. Skilled nursing services\*\*\*
3. Physician visits\*\*\*
4. Medical equipment and supplies
5. *Prescription medication*
6. *Mental health counseling\*\*\**

\* The home setting is the preferred site for chronic care.

\*\* Used as an offset to hospitalization and where home care is not feasible.

\*\*\* Subject to appropriateness review.

Chairman STARK. Thank you very much.  
Dr. Lipkin.

# **STATEMENT OF MACK LIPKIN, JR., M.D., PRESIDENT, SOCIETY OF GENERAL INTERNAL MEDICINE**

Dr. LIPKIN. Good morning, Mr. Chairman and members of the subcommittee.

My name is Mack Lipkin and I am a general internist practicing in Bellevue, in New York, and president of the Society of General Internal Medicine.

We are a national organization dedicated to the delivery of high-quality primary care and to research and education in primary care internal medicine.

A substantial portion of our practice serves disadvantaged and indigent populations and, equally important, we are the teachers of future primary care internists. It is our responsibility to attract medical students to primary care and to show them how to achieve excellent, cost-effective and satisfying care, and we need help in these missions.

We share the following perspectives: First, primary care should be the basic building block of a reformed health care system. Each resident should have their own primary care doctor who is a personal physician, a guide through the "medical jungle," facilitating access to appropriate specialists and community services, and protecting patients from inappropriate, unnecessary, dangerous, and costly specialty services. We believe that a system based on generalists is much more cost-effective than the one which now exists with dominance by specialists.

Second, our job, first and foremost, is to be advocates for the patient. Unless primary care providers are supported in this, physicians will not go into or stay in primary care.

Third, a federally mandated standard benefits package that is comprehensive for pediatric and adult patients is necessary, including immunizations and medically effective health promotion, preventive care, primary care, and case management, including well child care and periodic health examination, consultative specialty care, hospital care, appropriate diagnostic tests, medications and other medical supplies, mental health services, dental services, and home care.

Fourth, the standard primary care benefits should consist of first contact care, including diagnosis, treatment and case management, comprehensive care over long periods of time, coordination of specialty and community services, preventive care, and health promotion, and, therefore, must include coverage for minor self-limited diseases, chronic disorders, and acute life-threatening diseases.

Fifth, we believe that primary care and preventive services should be delivered in partnership with nurse practitioners, physician assistants, midwives, social workers, and community outreach workers. Federal incentives should insure an adequate supply of such partners.

Sixth, we believe that underserved populations require and deserve special attention. Their special needs must be factored into planning, to prevent bypassing them without effective access to



care. Examples of this are special services for HIV prevention and treatment and services for tuberculosis prevention and treatment.

The following are features that must be part of the standard benefits package:

First, it should be federally mandated and monitored for content and quality, to prevent disparities in coverage as now exist from State to State and locale to locale. The benefits package should not be linked to employment status, so that such benefits are available to all Americans.

Provider reimbursement needs to be redirected to favor cognitive and management services. Patients must have incentives, rather than barriers, to the use of primary care and preventive care.

Finally and most important, perhaps, from our point of view, immediate attention is needed to increase the attractiveness of careers in primary care. Even with prompt action, the generalist/specialist imbalance with its attendant costliness will persist well into the next century.

Needed measures include much improved economic incentives to practice primary care, and support for entry such as loan forgiveness programs, and differential and increased support for primary care training at the medical school and residency levels. Presently, \$5.2 billion support the current specialist producing system, while only \$0.17 billion supports primary care training.

We appreciate the opportunity to present our views to you. We look forward to participating with you in the process of change and offer whatever help we can provide to the committee and its staff.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF MACK LIPKIN, JR.**  
**Society of General Internal Medicine**

My name is Mack Lipkin, Jr., and I am a general internist and President of the Society of General Internal Medicine (SGIM). SGIM is a national organization of over 2,200 physicians who are dedicated to the delivery of high quality primary care and to research and education in primary care general internal medicine. The majority of SGIM members are based in academic health centers where we provide primary care general internal medicine and prevention-oriented services. The most common disorders we care for include upper respiratory tract infections, women's health problems, hypertension, ischemic heart disease, arthritis, diabetes, anxiety, depression, and substance abuse. We also care for HIV-positive and AIDS patients. A substantial portion of our practices serve disadvantaged and indigent populations. Equally important, we are the teachers of future primary care internists. It is our responsibility to attract medical students to primary care and show them how to achieve excellent, cost-effective and satisfying care. In all these missions, we need your help. From our experience in health care delivery, health services research and the teaching of students and residents, we share the following perspectives:

First, SGIM believes that primary care should be the basic building block of a reformed American health care system (1). All Americans should have their own primary care doctor (2), who is a personal physician (3) to serve as a guide through the "medical jungle" facilitating access to appropriate specialists and community services, and protecting patients from inappropriate specialty services (4). A system based on primary care delivered by generalists is much more cost-effective than the one which now exists with dominance by specialists.

Second, our job, first and foremost, is to be an advocate for the patient (the positive gatekeeper role). Unless primary care providers are supported in this "positive gatekeeper" role, physicians will not go into or stay in primary care. SGIM believes that the primary care physician must not be placed in the role of restricting access to care (the negative gatekeeper role). We are trained to take on the tasks of patient care management and to serve as the patient's trustee. We believe strongly that there will be substantial savings with a positive gatekeeper role.

Third, SGIM believes that one major way to support primary care physicians is to develop a federally-mandated standard benefits package that is comprehensive for pediatric and adult patients, including:

1. Immunizations and medically effective health promotion and preventive care.
2. Primary care and case management.
3. Consultative specialty care.
4. Hospital care.
5. Appropriate diagnostic tests.
6. Medications, glasses, hearing aides, and other medical supplies.
7. Mental health services.
8. Dental services.
9. Home care.
10. Long term care.

Fourth, SGIM believes that standard primary care benefits should consist of: 1) first contact care, including diagnosis, treatment and case management; 2) continuous and comprehensive care over long periods of time; 3) coordination of specialist and community services; 4) preventive care and health promotion, preferably for a defined population. Therefore, standard primary care coverage must include minor, often self-limited illnesses; chronic disorders; and acute, life threatening diseases, as well as preventive care (5).

Fifth, SGIM believes that the best primary care and preventive services can be delivered in a partnership with nurse practitioners, physician assistants, midwives, social workers, and community outreach workers (6). Federal incentives are needed to ensure an adequate supply of such partners.

Sixth, SGIM believes that underserved populations require and deserve special attention. Current health care expenditures are clustered such that 1% of the population uses 30% of the services and less than 3% are used to meet public health objectives (7). Federal targets for the distribution of resources between preventive, primary, secondary and tertiary care need to be developed. Federal monitoring of targets and corrective action will prevent the emergence of wide disparities of benefits between states and population groups. The special needs of the disadvantaged must be factored into planning.

In summary, SGIM believes that the following components must be part of the standard health benefits package:

1. The standard health benefits package should be comprehensive, including not only primary and preventive care, but also the other benefits listed above.
2. The standard health benefits package should be federally mandated and federally monitored for content and quality. The present disparities in private health insurance benefits and state medicaid benefits must not be allowed to develop.
3. The standard health benefits package should not be linked to the beneficiary's employment status and should be based on common financing mechanisms so that health care benefits are shared equally by all Americans.
4. Provider reimbursement needs to be redirected to favor cognitive and management services, shifting reimbursement from high cost procedures to primary care services. Unless this happens, those choosing primary care careers will continue to decline. Direct reimbursement supplements should be offered for case management, disease prevention, and health promotion services.
5. There should be no co-payments or deductibles for primary care and preventive services, including home visits, office visits and hospital visits, when conducted by a primary care provider. In order to enhance the health system's effectiveness, patients must have incentives, rather than barriers, to the use of primary and preventive care.
6. Access to non-emergent specialty care should in most instances be contingent on primary care referral. Direct access to consultative care should be discouraged by monetary and other disincentives, but should remain an option.
7. Programs for preventive care and health promotion should be developed that encourage primary care physicians to deliver these services to defined community populations.
8. The standard health benefits package should contain provisions to address the special needs of underserved and high risk populations, such as enhanced financing for providers who offer substance abuse treatment, adolescent or elderly services, HIV and AIDS services, community-based mental health services, etc.
9. Incentives should be designed to encourage primary care physicians to practice in groups with nurse practitioners, physician assistants, midwives, social workers and community outreach workers.
10. Medical education funding should not reduce funding for benefits. All payers must support medical education. Funding for medical education should favor primary care education and should be expanded to include ambulatory care organizations, community providers and hospital-based ambulatory care programs, in order to shift health professional training from inpatient care to ambulatory care.



11. Finally, immediate attention is needed to increase the attractiveness of careers in primary care. Even if prompt action ensues, the generalist/specialist imbalance with its attendant costliness will persist well into the next century. Needed measures include:
  - a. Much improved economic incentives to practice primary care;
  - b. Differential and increased support for primary care training at the medical school and residency levels. Presently, \$5.2 billion supports specialist residency training, while only \$0.17 billion supports primary care training;
  - c. Support for research, teaching, and evaluation in primary care, including innovative programs that combine teaching and service delivery.

SGIM appreciates the opportunity to present our views and proposals for national health care reform. We look forward to participating in the process of change and offer whatever help we can provide in refining the above proposals together with the Committee and its staff.

Thank you for giving the Society of General Internal Medicine the opportunity to share our views with you.

#### FOOTNOTES

1. Comprehensive Health Care for the United States, a Statement of Principles: SGIM News, October 1990.
2. Comprehensive Health Care for the United States, a Re-statement of Principles: SGIM News, October 1992.
3. Starfield, Barbara, Primary Care: Concept, Evaluation and Policy. Oxford University Press, 1992.
4. Grumbach K, Fry CB. Managing primary care in the United States and in the United Kingdom. N Eng J Med 1993;328:940-45.
5. Rosenblatt RA, Cherkin DC, Schneewiess R, Hart LG. The content of ambulatory medical care in the United States. N Eng J Med 1983;309:892-7.
6. Nutting PA, ed. Community Oriented Primary Care: from principle to practice. Albuquerque: University of New Mexico Press, 1990.
7. Data and concept from Steven Miles, MD and Nicole Lurie, MD, University of Minnesota, Minneapolis, MN.

Chairman STARK. Thank you, doctor.  
Dr. Pearson.

**STATEMENT OF HOWARD A. PEARSON, M.D., PRESIDENT,  
AMERICAN ACADEMY OF PEDIATRICS**

Dr. PEARSON. Mr. Chairman and members of the subcommittee, I am here today representing 45,000 physicians who are concerned with the health of America's children.

There are, to be sure, millions of smart, healthy, well-cared for children growing up in America. However, today's generation of young are the first in our Nation's history to be, on the average, less healthy, less educated and less likely to prosper than their parents. We can do better.

Many proposals have and will be made concerning health care reform. Unfortunately, many policymakers are under the misconception that if they address the health care needs of adults, that children will automatically be taken care of. This is simply not true, and the historical record suggests the contrary. The child is not a small adult and one size simply does not fit all.

The American Academic of Pediatrics has developed a health care reform proposal entitled "Children First," emphasizing the importance of preventive care and containing a benefits package specifically addressing the health care needs of children and of pregnant women. This benefit package is included in H.R. 727, the Children's and Pregnant Women's Health Insurance Act, legislation introduced by Representative Robert Matsui of California.

We believe that the principles of H.R. 727 should be the children's piece of any health care reform measure that is enacted. Preventive care is a critical component of children's health care and must be included in the standard benefits package. It should also include acute and hospital medical services, as well as services for children with special health care needs.

To make health care reform work, we need to insure that every child has a medical home. The medical home concept gets to the very heart of the issue of quality and comprehensiveness. A medical home should provide regular and ongoing health care that is available around the clock 365 days a year and includes preventive care, early detection and treatment of acute diseases, and the co-ordination of care for those children with chronic or handicapping conditions.

The present status of children's health care in our country demands that their needs be addressed in any health care reform debate. The standard benefits package must be comprehensive and address the very special needs of children.

The American Academy of Pediatrics urges you to take prompt action to insure that all children and pregnant women have access to the kind of basic health care that many are currently denied.

I thank you.

[The prepared statement follows:]

**TESTIMONY OF HOWARD A. PEARSON, M.D., F.A.A.P.  
American Academy of Pediatrics**

Mr. Chairman, members of the Subcommittee, I am Howard Pearson, M.D., President of the American Academy of Pediatrics. I am here today representing 45,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Thank you for inviting me to this important hearing.

The American Academy of Pediatrics commends the Chairman for holding today's hearing, which clearly demonstrates his commitment to the critical issue of health care reform, and the need for an appropriate standard health benefits package.

The future health and economic prosperity of our nation is at risk. Many of our children are not receiving the health care to which they are entitled. My message today is that we can no longer afford to ignore the health needs of our children.

Here's what we face:

\* In 1991, an estimated 11.8 million children and youth under age 21 had no health care coverage. (EBRI);

\* It's not just the poor: two-thirds of uninsured children live in families with incomes above the Federal poverty level which was \$13,400 for family of four in 1991. (EBRI);

\* Each year in the United States, nearly 40,000 babies die before reaching age one. The infant mortality rate is 9.8 deaths for every 1,000 births. Our rich and compassionate country lags behind 20 other nations in infant mortality. (U.S. Department of Health and Human Services, 1991);

\* In 1991, only 43% of children had been adequately immunized against childhood diseases (Cutts, et al. 1992; National Vaccine Advisory Committee, 1991);

\* One out of five adolescents have at least one serious health problem. (Office of Technology Assessment 1991).

Although there are, to be sure, millions of smart, happy well-cared for children growing up in America, today's generation of young are the first in the nation's history to be on the average, less healthy, less educated and less likely to prosper than their parents.

We can do better. We MUST do better.

CHILDREN HAVE UNIQUE HEALTH CARE NEEDS

To address the problems in our current health care system, many proposals have been put forward to reform our health care system. Unfortunately, many policy-makers are under the misconception that if they address the health care needs of adults, then children will automatically be taken care of. This simply is not true. The child is not a small adult; and many of the health needs of children are not those of adults.

BENEFIT PACKAGE MUST BE APPROPRIATE FOR CHILDREN AND PREGNANT WOMEN:

To ensure that the health care needs of children and pregnant women would be addressed in the health care reform debate, the American Academy of Pediatrics developed it's own health care reform proposal entitled: "Children First". This proposal emphasizes the importance of preventive care, and contains a benefit package (see attached) developed by the Academy specifically addressing the health care needs of children and pregnant women. We believe this benefit package should be included in any health care reform package that Congress considers.

The Academy's benefit package is comprehensive. It includes: preventive health care with no cost-sharing, primary major medical services, and extended medical services.



H.R. 727, "THE CHILDREN AND PREGNANT WOMEN HEALTH INSURANCE ACT":

The Academy's recommended benefit package is included in H.R. 727, "The Children and Pregnant Women Health Insurance Act", legislation introduced by Rep. Robert Matsui (D-CA) and modeled after the Academy's "Children First" legislative proposal. The American Academy of Pediatrics commends Congressman Matsui for his action and strongly supports H.R. 727 as the "children's piece" of health care reform.

PREVENTIVE HEALTH CARE:

Preventive care is a critical component of children's health care, and must be included in the standard benefit package. The value of preventive medicine can be shown through examples of immunization; newborn screening for PKU (phenylketonuria) and congenital hypothyroidism; early detection and treatment of infectious diseases, orthopedic problems, vision and hearing impairments.

For example:

\* One dollar spent on immunizations saves ten in treatment for childhood diseases (Select Committee on Children, Youth and Families 1985);

\* One dollar spent on quality prenatal care saves more than three in caring for low birthweight babies (Institute of Medicine 1985);

\* One dollar spent to educate a parent about ways to keep their child healthy pays untold dividends in preventing illness.

Society is finally learning the painful lesson that the pound of cure is far more costly than the ounce of prevention.

Many costly consequences of inadequate health care of children and pregnant women do not show up on the cost sheets of the health system. The costs and consequences of malnutrition, anemia, substance abuse, teen pregnancy and lack of immunizations may not be fully appreciated as health costs, rather they show up on the ledgers of the social services, education or correction systems.

PRIMARY MAJOR MEDICAL SERVICES:

Primary major medical services should also be included in the standard benefit package. This includes the following: hospital care, physician services for acute and chronic conditions; laboratory and other diagnostic services; acute dental care; medical and surgical supplies; corrective eyeglasses and lenses; hearing aids; medical equipment; and prescription drugs, including nutritional supplements.

EXTENDED MEDICAL SERVICES:

The standard benefit package should cover services for those children and adolescents with special health care needs.

Only one in five children who need mental health treatment and less than one in eight adolescents who need alcohol or other drug abuse treatment receive it. Private insurance plans are more likely to limit coverage for mental health and substance abuse treatment than other physical health problems; a survey of corporate benefit decision makers found that more than half predicted restricting or excluding dependent coverage for mental health and drug abuse treatment services. (U.S. Department of Health and Human Services, 1990; National Association of State Alcohol and Drug Abuse Directors. 1990: OTA 1991).

### MEDICAL HOME

To make health care reform work, we need to ensure that every child has a medical home. The medical home concept gets to the very heart of the issue of quality. The medical home should provide regular and ongoing comprehensive health care available around the clock, every day and include preventive care, early detection and treatment of acute diseases, and the coordination of care for those with chronic or handicapping conditions. It's interesting to note that a study for all Medicaid eligible children from the state of Michigan reported that children who began an illness episode in an outpatient hospital department had expenditures between 68% and 119% greater than other Medicaid-eligible children with the same illnesses who began their episodes of care in office practices. In addition to excessive cost, emergency room visits disrupt continuity of care.

Obviously, I believe that for children and adolescents, a medical home is best provided by a pediatrician. I am aware that our current pediatric workforce needs to be supplemented with a variety of other health professionals, and that other sites, such as community centers and other clinics, will be utilized.

### CONTAINING COSTS:

This year represents a window of opportunity for us to reform our health care system so that children get the care they need. Recognizing the importance of cost-containment as a part of the health care reform issue, we want to emphasize that children are a superb investment of health care dollars since the cost of their care is so low and their potential societal contributions so high.

As policy-makers consider a spectrum of solutions in health care reform such as managed competition, global budgets and other concepts to contain costs, we must assure that children are guaranteed adequate funding for the appropriate health care they need, and that such funding be protected.

The fact is children are 28% of the population but account for only 11% of all health expenditures. They comprise 51.8% of Medicaid recipients but receive only 21% of Medicaid funding.

### COSTS FOR CHILDREN

To fairly estimate costs for children, we must ensure:

First, the explicit recognition of the required benefits for children: The benefit package must be based on the resources actually required to provide care, rather than extrapolations from historical experience, which, through access barriers and inaccurate pricing methods unfairly reflect depressed levels of service use and cost.

Forcing health plans to make tradeoffs across the full spectrum of benefits in order to meet budget targets creates the risk that prevention benefits would be opted out in favor of costly services to acutely ill adults. This potential concern is heightened by the fact that many needed prevention services traditionally have never been covered under private insurance benefits. Even in the settings in which these benefits have been covered (e.g., Medicaid's EPSDT program), access problems have artificially depressed utilization.

Second, the appropriate service use by children: That is, rather than basing service use on observed utilization in settings where children have faced significant access barriers (e.g., EPSDT), these assumptions should be based on the current state of clinical knowledge about appropriate frequency of services.

Third, reasonable service pricing: With fair and appropriate reimbursement for services. If the Resource Based Relative Value Scale (RBRVS) payment mechanism is imposed, then a pediatric-specific RBRVS must be developed.

#### PRINCIPLES FOR HEALTH CARE REFORM

The Academy believes that the following principles are necessary to promote an effective health care reform plan for children and pregnant women:

- 1) CHILDREN FIRST: If the health care reform plan is to be phased-in, children and pregnant women must be phased-in first;
- 2) GUARANTEED ACCESS: All children through age 21 and pregnant women should be guaranteed financial access to health care. The availability of insurance to children should not be left to chance;
- 3) APPROPRIATE BENEFIT PACKAGE: The American Academy of Pediatrics' recommended benefit package is a necessary component of any health care reform package, providing children and adolescents with the appropriate services they need with an emphasis on prevention;
- 4) ONE-CLASS: All children and pregnant women should have access to the same benefit package. Medicaid should be replaced.
- 5) INSURANCE REFORM: Insurance reforms such as elimination of pre-existing condition exclusions, and guaranteed issue and re-issue, along with community rating should be required.

Medical liability reform should also be addressed as part of health care reform.

The present status of children's health care in our country demands that their needs be addressed in the health care reform debate. The standard benefit package must be comprehensive, as opposed to "bare-bones". It should be specific to children's needs, not vague with details "to be determined later." The American Academy of Pediatrics urges prompt action to ensure that children and pregnant women have access to the health care they are entitled to. We look forward to working with you as Congress considers this issue.

Thank you.



## BASIC BENEFIT PACKAGE

**1. Preventive Care Benefit Basket:** Specific benefits for which no cost sharing applies. All preventive services should be covered according to the AAP periodicity schedule:

- Child preventive care, including:
  - Routine office visits
  - Routine immunizations
  - Routine laboratory tests
  - Preventive dental care
- Prenatal care, including:
  - Care of all complications
  - Family planning
- Care of newborn infants, including:
  - Attendance at high-risk deliveries
  - Normal newborn care (inpatient)
- Child abuse assessment

**2. Primary/Major Medical Benefit Basket:** Specific benefits for which some cost share applies:

- Hospital services:
  - All inpatient care for acute and chronic conditions
  - Emergency room care
  - Transport to hospital or health facility
  - Treatment for injury to normal gums and teeth
  - Acute home health care on a short-term basis
  - Surgery and anesthesia services
  - Therapeutic radiology services
  - Nursing care
- Physician services:
  - Inpatient and outpatient physician care for acute and chronic conditions
  - Subspecialty consultations and treatment

- Diagnostic services
  - Diagnostic radiology services
  - Laboratory tests
  - Diagnosis of developmental and learning disorders
- Acute dental care
- Medical and surgical supplies
- Corrective eyeglasses or lenses
- Hearing aids
- Medical equipment
- Prescription drugs, including nutritional supplements

**3. Extended/Major Medical Benefit Basket:** Specific benefits for which cost sharing applies. Criteria will be established to trigger the need for care coordination. Primary care physician will be involved in development of plan of care.

Services include:

- Care coordination for chronically ill and other "at-risk children"
- Orthodontia not covered above (other than cosmetic)
- Treatment of developmental and learning disabilities
- Mental health services
- Substance abuse services
- Speech therapy
- Occupational therapy
- Physical therapy
- Hospice care
- Respite care
- Recuperative stays in long-term care facilities
- Nutritional assessment and counseling

Chairman STARK. Thank you very much.  
Dr. Fried.

**STATEMENT OF LINDA FRIED, M.D., MEMBER, AMERICAN  
GERIATRICS SOCIETY**

Dr. FRIED. Good morning, Mr. Chairman and members of the subcommittee.

I am Dr. Linda Fried. I am a geriatrician and a faculty member of the Johns Hopkins University School of Medicine. It is my pleasure today to appear before this committee to present the American Geriatric Society's support for including comprehensive geriatric assessment in the health care reform benefits package.

The society is a 6,000 member organization dedicated to the advancement of research, education and clinical practice relevant to the medical care of older persons. Members of the society focus their professional efforts exclusively on the medical needs of Medicare patients. For most of us, caring for the patient under the age of 80 is the exception, rather than the rule.

First, I would like to say that although the major focus on health care reform has been on the population under age 65, health care reform is equally crucial for senior citizens. As you know, the Medicare program was originally established as an insurance plan for seniors and later the disabled that covers major medical illnesses, with a particular focus on acute care hospitalization. However, through experience, we have come to learn that the Medicare program is inadequate to meet the special care needs of seniors.

We believe that the health care reform debate provides a unique and exciting opportunity to make sure the care all citizens receive meets their medical needs. Because Medicare does not currently do that, Medicare reform should be included in the package.

Comprehensive geriatric assessment is a powerful and important, but labor-intensive tool for improving diagnosis and care planning for elderly patients with multiple or complicated illnesses. It has been shown to improve health care outcomes in several studies in different settings, with particular benefits for frail patients.

Using the comprehensive geriatric assessment process leads to more accurate diagnosis and functional improvement in frail elderly persons. Its benefits include improved diagnostic accuracy, improved functional and mental status and more appropriate use of medications. This means that patients are able to stay well longer and avoid going to a nursing home as long as possible, which alleviates extremely high costs to both the patient and the Government. In fact, comprehensive geriatric assessment can actually decrease inappropriate high-tech and nursing home care.

The population of elderly persons in the United States is growing with extraordinary rapidity, as is well known to this committee. Although the majority enjoy good health, many older people suffer from multiple illnesses and significant disability.

Comprehensive geriatric assessment is especially suited to identify the great medical complexity and vulnerability many older individuals tend to have. These situations include illnesses with atypical and obscure presentations, illnesses that cause major cognitive, effective and functional problems, or situations which may

put these patients at high risk of premature or unnecessary institutionalization.

I would like to describe to you what a comprehensive geriatric assessment entails. The 1987 National Institutes of Health Consensus Development Conference on Geriatric Assessment defines it as an evaluation that uncovers, describes, and explains the multiple problems of older persons. The assessment evaluates the following factors to do this:

First, the patient's history, both physical and mental, including their use of prescription and nonprescription medications. The patient's nutritional status is evaluated, as well as the patient's physical functioning, which includes evaluating risk of falling, incontinence, immobility and difficulty caring for him or herself, problems highly prevalent and relatively unique to the older population.

The patient's health behaviors, such as smoking, exercise, alcohol use, immunization status and sexual function are evaluated, as well as the patient's informal support network, including the relatives and friends that are often critical in assisting in daily activities.

To fully understand the needs of the patient, the assessment usually includes family members and other important persons in the patient's environment. The assessment is usually conducted by a core team that consists, at a minimum, of a physician, nurse and social worker, each with special expertise in caring for older people. Frequently, a psychiatrist is a member of the core team.

After this information is gathered, the team develops a comprehensive list of the patient's needs and strengths, recommendations are integrated into an individualized plan of care, including desired outcomes. This plan focuses on providing targeted appropriate services, while discouraging the use of inappropriate services. The preferences of the patient and family must be blended into this process.

The 1987 Consensus Conference concluded that the assessment is effective, when coupled with ongoing implementation of the developed plan of care. This requires the integration of the assessment process into the health care system and the array of social services available in the community.

Additional evidence of comprehensive geriatric assessment's effectiveness is its positive application within the Veterans Hospital system. Research sponsored by the Veterans Administration revealed that hospitalized older patients who receive these assessments were less likely to die, less likely to be readmitted to the hospital, and less likely to require nursing home care than other frail elderly patients discharge from VA hospitals.

The Veterans Administration has acted on this information by establishing geriatric evaluation and management units at most VA hospitals around this country. Unfortunately, Medicare continues to ignore this helpful tool to providing appropriate care.

In terms of costs, initial estimates from the Veterans Administration program show that the costs of a comprehensive geriatric assessment was \$50 in 1991. It was offset by \$5,000 savings per year for each hospitalized patient and a \$2,500 savings a year for each nursing home patient.



Another evaluation from the University of Nebraska showed the estimated savings to the Medicare and Medicaid programs to be \$136 million, which more than offsets the \$24 million estimated cost of comprehensive geriatric assessments.

In conclusion, as the committee works with the administration and considers the appropriateness of the benefits package established in the health care reform proposal that will be enacted, we strongly urge you to include comprehensive geriatric assessment in the package, since comprehensive geriatric assessment improves diagnostic accuracy, as well as the functional and mental status of seniors with multiple illnesses and chronic illnesses. Including this benefit will assure that seniors will get the comprehensive, appropriate care they need in the settings that are most efficient and effective.

I thank you very much for your time.

Chairman STARK. Thank you.

Dr. Hoehn.

**STATEMENT OF JAMES G. HOEHN, M.D., PRESIDENT, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.**

Dr. HOEHN. Thank you very much.

I am Dr. James Hoehn, a practicing plastic surgeon from Albany, N.Y., and president of the American Society of Plastic and Reconstructive Surgeons, otherwise known as ASPRS. We represent approximately 5,000 plastic surgeons or 97 percent of those plastic surgeons certified by the American Board of Plastic Surgery, and we serve as the spokesperson for the specialty of plastic surgery.

As this committee knows all too well, and the American public is becoming rapidly aware, the development of a basic set of health care benefits will become the most arduous and important task in reforming our health care payment system.

The minimum benefits package must straddle the fine line between providing the necessary services desired by all Americans and those services that the American public is able and willing to pay for.

Plastic surgeons often find themselves perceived as providing only cosmetic surgery. Whereas, the actual practice of members of ASPRS is over 60 percent reconstructive and includes a number of procedures which we feel are necessary and should be in the minimum benefits package. Examples might include repair of severed flexor tendons and nerves in the injured hand, or repair of the lip and the pallet in the child born with a cleft or harelip.

Plastic surgeons support significant health care reforms, because it will permit all physicians to provide necessary medical services to all Americans. With universal access, each patient should be able to seek the correct treatment earlier in the disease process. This series of events will significantly lower health care costs.

ASPRS has given careful thought to two aspects of the minimum benefits package as we currently understand it, the definition and the composition, and we offer the committee its current thoughts.

For the debate on the definition of a minimum benefits package, ASPRS would like to offer its definitions of reconstructive and cosmetic surgery. These have been adopted by the American Medical

Association and generally accepted by the medical community. We have submitted these definitions to the White House task force and suggest that the subcommittee consider them in the subcommittee's deliberations on the basic definition of the minimum benefits package.

The salient portions of these definitions are that reconstructive surgery is performed on abnormal structures, whereas, cosmetic surgery is performed on essentially normal structures. The complete definitions are included in our written submissions. ASPRS does not advocate inclusion of any of the latter procedures in the minimum benefits package.

In trying to apply these definitions to clinical services, our patients often expect and demand us to be their advocates with third-party payers in certain gray areas. For example, management of benign skin lesions are currently included in the Medicare fee schedule, but may not fit the criterion of a tightly defined minimum benefits package. ASPRS will be pleased to help establish these difficult distinctions.

The ASPRS has recently undertaken a survey of its membership to determine those plastic surgery procedures which should be included in the minimum benefits package. Once this survey is completed, which we estimate will happen within about 30 days, ASPRS will provide the subcommittee with a copy of the results.

The extent and types of procedures to be included in the minimum benefits package will be controlled by the definition of the minimum level of service to be included. If the definition is rigidly controlled, the package may well, for example, exclude or define whether breast reconstruction following mastectomy will be included in the package or would be covered by a supplemental benefits package. These decisions, as you know, are highly politically charged and have significant potential fiscal implications.

Perhaps the proper place for a policy pertaining to the inclusion or exclusion of such benefits belongs in a widely representative national body. Plastic surgeons believe their input in this arena will be helpful. Once the definition of the minimum benefits package is determined, the appropriateness of inclusion of any procedure must be periodically evaluated. The development of clinical indicators and practice guidelines are under development by ASPRS and a number of other specialty societies, such as ASIM and the American Medical Association.

The impact of the implementation of these parameters will provide a benchmark against which to judge the appropriateness of any procedure to be included or excluded from the package. ASPRS, and I am sure many other groups, stand willing, ready and able to provide the professional judgments which will be needed to make safe and effective adjustments to the composition of the minimum benefits package.

I thank you for your attention and I would be happy to answer any questions.

[The prepared statement follows:]

**TESTIMONY OF JAMES G. HOEHN, M.D.**  
**American Society of Plastic and Reconstructive Surgeons, Inc.**

Good Morning. I am Dr. James Hoehn, a practicing plastic surgeon from Albany, New York and president of the American Society of Plastic and Reconstructive Surgeons. The ASPRS represents approximately 5,000 board-certified plastic surgeons and serves as the voice for plastic surgery. The Society's membership is comprised of 97% of the plastic surgeons certified by the American Board of Plastic Surgery.

I would like to thank the chairman for the opportunity to speak with you today on this very important topic.

As this Committee knows all too well, and the American public is becoming aware, the development of a basic set of health care benefits will become the most arduous and important task in reforming our health care payment system. The benefits package must straddle the fine line between providing the necessary services desired by all Americans and those services that the American public is able and willing to pay for. The more extensive the package, the longer it will take for universal access to be achieved and the longer the present trends in health care management will continue to burden our economy.

Plastic surgeons are concerned, as are all other conscientious American physicians, that all Americans receive necessary health care benefits that will permit them to lead a normal and productive life. Although the public often perceives the specialty of plastic surgery as only involved in cosmetic or aesthetic surgery, the practice of members of the American Society of Plastic and Reconstructive Surgeons is over 60% reconstructive in nature. Therefore, many procedures and services which plastic surgeons routinely provide to patients are appropriate to include in a minimum benefits package. Examples include repair of cut tendons and nerves in the injured hand and repair of the lip and the palate in the child born with a cleft or "hare" lip.

ASPRS is completing an extensive survey of its membership to determine the basic procedures performed by a plastic surgeon which should be included in the minimum benefits package. Once this survey is completed, ASPRS will be happy to provide the Committee with a copy of the data.

The ASPRS would also like to offer its definitions of reconstructive and cosmetic surgery, that have been adopted by the American Medical Association and generally accepted by the medical community and insurance industry. We recommend that the Committee consider these as the basis for a definition of the composition of a minimum benefits package.

***RECONSTRUCTIVE SURGERY** is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.*

***COSMETIC SURGERY** is performed to reshape normal structures of the body in order to improve the patient's appearance.*

Let me make it clear that ASPRS does not advocate inclusion of any aesthetic or cosmetic procedures in this package.



The extent and types of procedures included in the minimum benefits package will, by necessity, be controlled by the definition of "the" minimum levels of service which are to be included. If, for example, the definition would be very rigidly controlled, the minimum benefits package might well include breast reconstruction following a mastectomy using an implant, but may exclude reconstruction of the breast following mastectomy for cancer with the woman's own tissues - a procedure felt by many plastic surgeons and patients alike, to be the optimal reconstructive procedure. Care and treatment of other congenital defects, traumatic conditions, and reconstructive surgery following treatment for tumors, infection, and other disease states may also be excluded.

If this constricted version of the minimum benefits package is chosen, it does provide for rapid implementation and low cost financing. This type of package will, as implied above, permit access to functional health care for all Americans. However, Congress should not allow penalties of any sort to be placed on any American who wishes to expand his or her health care coverage protection. The Committee may wish, in its deliberations and recommendations, to define a several tiered system which would permit the consumer to seek and purchase that health care protection which meets his or her specific needs. Similarly, the consumer should be free to seek other medical services to improve the "quality of life" without the burden of taxation. While we will occasionally recommend a traditionally aesthetic procedure to be used in a reconstructive setting, this usage would be considered an "outlier." For example, 10 days ago I performed a face lift and blepharoplasty to reconstruct one side of the paralyzed face of a patient.

Once the definition of the minimum benefits package is determined, the appropriateness of inclusion of any procedure must be periodically evaluated. The development of clinical indicators, practice parameters and practice guidelines are under development by ASPRS and other specialty societies with assistance from many interested groups. The impact of the implementation of these parameters will provide a ready benchmark against which to judge the appropriateness of any procedure to be included in "the package." ASPRS, and, I'm sure, many other groups stand ready and willing to provide the professional judgements and decisions which will be needed to make safe and effective adjustments to the composition of the minimum benefits package.

Thus, the inclusion of the provider in any and all deliberations regarding the definition and composition of the minimum benefits package would seem obvious. To date, however, in spite of a court mandate to open the deliberations, it is my personal opinion that meaningful involvement of any practicing provider, individually or by groups, in the reform process has not occurred. We wish the Committee to recognize this absence and make provisions for its correction.

On behalf of the American Society of Plastic and Reconstructive Surgeons, and its 5,000 members, I thank you for the opportunity to present our views. I would be happy to answer any questions.

Chairman STARK. Thank you, doctor.  
Dr. Gulya.

**STATEMENT OF JULIANNA GULYA, M.D., MEMBER, AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY**

Dr. GULYA. Thank you.

Mr. Chairman and members of the subcommittee, I am Dr. Julianna Gulya, and I am testifying today on behalf of the American Academy of Otolaryngology-Head and Neck Surgery, the world's largest medical organization of physicians and scientists who deal with disorders of the ears, nose, throat, face, head, and neck.

We appreciate the opportunity to present our testimony today you today in support of inclusion of universal infant hearing screening in any minimum health benefits package.

In March of this year, the National Institute of Deafness and Other Communication Disorders of the National Institutes of Health convened a panel of expert physicians and scientists into a conference to discuss the issue of "early identification of hearing impairment in infants and young children." The consensus statement that emanated from this conference reports that 1 of every 1,000 of the 4 million babies born yearly in the United States has a severe hearing disorder.

While reliable technology exists today to screen infants for hearing loss, the majority of babies in the United States escape detection until nearly the age of 3 years, and in some cases as late as 6 years. This situation is unacceptable. The first few years of life are critical to the normal development of speech and language skills, and children with hearing impairments who do not receive special training before the age of 2 suffer permanent deficits in speech and language.

Late detection of hearing loss in infants carries serious financial and emotional consequences for the child and even society as a whole. The child suffers emotionally, cut off from many in society, for an inability to communicate, and the resultant frustration often erupts into hyperactivity and generally disruptive behavior. Additionally, late detection of hearing loss can lead to poor self-esteem, difficulty with social interactions, and ultimately poor social adjustment.

The costs to society can be seen in poor academic achievement by such individuals, resulting in poorer productivity and earning ability. According to Downs, the loss of income earning potential for the hearing impaired costs society \$79 billion a year. It is clear that the growth and development of our high-tech society, as we go into a very competitive 21st century, hinges upon communication, as changes in employment over the past 25 years dramatically illustrate.

In almost all of the new jobs created, communication skills are critical. Few new jobs depend upon physical strength and the jobs of the future will increasingly require communications and language sophistication, not merely to punch buttons, but to know which buttons to push. The costs of hearing impairment to society will inevitably increase.



Figures for the cost of identifying a single hearing-impaired infant range from \$3,000 to \$5,500, although the cost of testing one infant could be as low as \$25. While some might argue that such costs may be prohibitive, even at the low end, we believe that the costs of not identifying these babies is far greater.

It costs \$29,000 a year per person to educate a hearing impaired child in the school for the deaf, and the estimated total cost of educating all profoundly deaf individuals is estimated at \$122 billion. The earlier the identification of hearing loss in a child, the smaller the cost to society by mainstreaming that child, and by improving earning ability, estimated at \$129 million a year in the profoundly deaf alone.

The NIDCD Consensus Conference favored a policy of universal infant screening by means of otacoustic emission testing, preferably at birth, but in no case later than 3 months of age. OAE is quick, nonevasive, sensitive and can be automated, allowing for the use of minimally trained volunteers and, hence, lower screening costs.

Any screening program in a quality health care system must incorporate followup in both diagnostic and therapeutic arms, to be effective. Upon detection of a hearing loss in a child, the academy believes that it is preferable to have the child referred to an otolaryngologist-head and neck surgeon for proper diagnosis and management.

While we understand that the costs associated with the implementation of a universal screening program appear high, the costs of undetected hearing loss are higher. A universal hearing screening program, coupled with quality diagnosis and rehabilitation of speech and language will, in the long run, reduce costs to society and improve the quality of life for those children born with a hearing disorder.

Thank you very much for your attention. I will be pleased to answer any questions you may have.

Chairman STARK. I want to thank all of you for your testimony.

I do have a request, in particular, of the AMA. I am aware that you had somebody or some firm work on coming up with the cost estimate, and to the extent that you would share your working papers with the committee, it would be of some interest to us how you arrived at the \$2,700 average.

I would suggest to you that we would obviously want to discuss that with our people who score these things, and we would be glad to tell you where we come up with different numbers. But it would be very helpful if we could subsequently—it doesn't have to be for the record, but it would be a matter of some interest. I know Mr. Thomas had indicated an interest, and the Chair would be interested in that, as well.

Secondly, for those of you who commented on an idea of some national board, I would suggest to you that the Chair, at least, has no interest in determining what the contents of the package would be, if I don't pay for it. We have no interest now in what Blue Cross puts in the package or what Aetna puts in the package or what General Motors and the UAW bargain for in their package. I don't pay for it.

But if we will be expected to be responsible to pay for or subsidize the package, then I don't think it is realistic for us to aban-



don the responsibility of what will be in the package and maintain the responsibility for paying for it. I just don't think that is a realistic division that we would make or, indeed, on behalf of the taxpayers that we represent would be the right thing for us to do.

I am not sure that something like PPRC, with whom we have worked, and/or other groups, that we couldn't find a comfortable advisory position. But I think the idea of taking government, if you will, out of the loop doesn't work, if government is going to pay for a good bit of the benefits. I just offer that in response to some of the testimony.

Further, I would just like to ask each of you, because it was suggested in testimony at an earlier hearing that employees have opted for freedom to choose their own physician over all other considerations. Whether that is cost, convenience, quality, that seems to remain a paramount issue.

I just wonder how you or your patients would react, if there was a health reform plan that, either through financial coercion or limitation, required Americans to join a system where it would be more difficult or more costly to not only initially choose a physician, but to continue that choice throughout the changing requirements as they go through life and age.

Is there anybody who thinks that the physician groups are willing to unanimously, in effect, say let's have staff model HMO's and, for all practical purposes, eliminate choice and/or fee-for-service options? Anybody ready to sign up for HMO or nothing?

[No response.]

Chairman STARK. No hands. You are going to love the picks, that is all I have got to say.

Dr. LAMBIRD. Mr. Chairman, those were three very interesting points that you raised. First, we will ask staff to provide you, and it might be actually easier to simply provide direct communications with Gordon Trapnell & Associates—

Chairman STARK. As I say, I know they did the work and it would be good for us to have—

Dr. LAMBIRD. We worked both them and with Wyatt Associates. We are comfortable with the data and we will be glad to provide you with correct names.

Chairman STARK. Thank you.

Dr. LAMBIRD. Second, with respect to the national board suggestion, in 3 years of trying to develop the benefits package which we have presented to you, we have become extremely conscious of the tradeoffs in dollars and in benefits, and the reason that we suggested the national board is to look at the benefits, not the dollars.

I think that the dollars, in point of fact, certainly does represent the responsibility of the U.S. Congress. We would have no quarrel there. It is how we trim the benefits package to meet the financing, and the benefits package, as you are gathering, is an exceedingly controversial, very difficult, arduous thing that our council has borne for now 3 years in developing this package.

With respect to the staff model HMO's and freedom of choice, Mr. Chairman, as Americans and as patients ourselves, as all of us will at some time be patients, we feel very strongly that what should be provided to Americans is Americans' right to freedom to choose.

It is for that reason the AMA has suggested that, while Congress defines the dollar benefits or the amount of tax credits or tax deductibility, that, in fact, any system provide at least three options, one of which certainly would be a managed care HMO option, one perhaps a reflection of the current UCR, and, third, a benefit payment package in which the amount to be paid for a given benefit is known.

We fully understand that many people will elect managed care systems and we are aware of that. We also think that there is a great deal of diversity in this country, and providing within the dollar limits of subsidization options to reflect the diversity of this country would be not only the American thing to do, but it would also be a very practical thing to do.

Thank you, sir.

[The following was subsequently received:]

**Average Premium for AMA Standard Benefit Package**  
by Gordon R. Trapnell\*

**1. Objective**

The purpose of this report is to document estimates prepared for the American Medical Association of the average premium required to pay for the AMA Standard Benefit Plan if provided by all employers in the U.S. to their full time employees and dependents, using the same mix of insurers as found in the current market for private health insurance.

**2. The AMA Standard Benefit Plan**

The AMA Standard Benefit Plan is a traditional comprehensive major medical plan covering hospital, physician and other acute medical services needed to diagnose or treat an accident or illness, subject to an annual deductible of \$350 (\$750 family) and 20% coinsurance on most covered services up to an out of pocket maximum of \$1,500 in any year (\$3,000 family). In addition, the plan covers a schedule of preventive care services similar to that recommended by the U.S. Preventive Services Task Force.<sup>1</sup> Inpatient services for mental and nervous conditions, and those for substance or alcohol abuse, are limited to 28 days in a calendar year. Highlights of the coverage are as follows.

- o Full coverage of medically necessary acute inpatient and outpatient general hospital care in semi-private rooms (or private rooms if medically indicated).
- o Full coverage of acute medically necessary physician services.
- o Full coverage of legend and life saving prescription drugs.
- o Full coverage of dental surgery necessary to repair damage sustained in an accident or through treatment of an illness, or to remove impacted teeth.
- o Limited coverage of other licensed professional practitioners, and only when prescribed by a physician. Many of the types of services provided by some covered practitioners (e.g. removal of corns by podiatrists) would be excluded.
- o Confinement in a nursing home or hospice, or the services of a home health agency or ambulatory hospice program when provided as substitutes for inpatient hospital care.

\* Gordon R. Trapnell is the President of the Actuarial Research Corporation and the Principal of Gordon R. Trapnell Consulting Actuaries, Ltd.



- o Full coverage of miscellaneous services and supplies usually covered by major medical insurance plans, i.e. prostheses, rental of durable medical equipment.
- o Limit on inpatient coverage for alcoholism and drug abuse to one treatment program, for up to 28 days or \$3,000 lifetime limit.
- o Treatment of mental and nervous conditions is limited to those for which (i) the neurobiological basis has been scientifically established and (ii) there is a reasonable prospect for substantial, measurable improvement.
- o Schedule of preventive care benefits by age of patient, not subject to cost sharing, following the recommendations of the U.S. Preventive Services Task Force.

A more detailed description appears in Appendix A. Matters not fully specified are assumed to be as found in the 1992 "High Option" plan offered to federal employees by the Association of Blue Cross and Blue Shield plans.

### 3. *Important Estimating Assumptions*

The cost of the AMA Standard Benefit Plan will vary by a number of factors, including the specific population to be covered, the conditions of eligibility, how much providers are paid, how what is medically necessary is defined and the process by which it is determined and a number of other important details relating to the insurance program. The cost will also vary by the specific providers offered by a limited panel insuring organization, and the reimbursement rates agreed to. There are thus a number of critical assumptions that must be made about how an insurance program offering the AMA Standard Benefit Plan would be structured that must be made in order to prepare a cost estimate. These are referred to as "policy assumptions". Those that have a major impact on cost are discussed below.

#### a. *Population Eligible*

The estimate is intended to relate to all persons who are either full time civilian employees or wives or dependent children of such employees who are under age 65 and resident in the U.S. (or territories). Full time employment is defined to mean averaging at least 25 hours of work per week for six months or more.

Persons who are eligible only for the military health care system or CHAMPUS are not included. Other public employees, including those of the federal government, are included. The Veterans Administration is assumed to continue to serve disabled

veterans as at present, without funding from employer sponsored plans. Thus the cost of treatment for certain service connected disabilities is not included. Similarly, the estimates exclude medical expenses relating to work related injuries, which are covered under workmen's compensation. State mental hospitals are also assumed to continue to operate without payment from employer sponsored plans.

Natural and adopted children are assumed to be covered until their 18th birthday or while full time students until their 22nd. Coverage is assumed to be terminated at the end of the month following the last month in which the employee was employed at least 100 hours. The effect of any COBRA extensions, conversion privileges or other continued coverage, such as in early retirement plans, is thus excluded from the estimates. (The average premium would be increased by about 2% to cover COBRA and conversion options.)

#### *b. Nature of Insurers*

The cost of any benefit package will vary by the levels of reimbursement set or negotiated by insurers and the process through which medically necessary services are determined. Thus the mix of insurers by type and levels of reasonable charges is assumed to be the same as would otherwise occur in 1993.

#### *c. Impact of Payment of Bad Debts*

Mandating coverage by all employers would have the impact of relieving providers of a major portion of uncompensated care. The additional income is not assumed to reduce support payments to hospitals to help pay for bad debts resulting from services to uninsured persons from federal or state governments (e.g. "disproportionate share" payments). It is further assumed that the additional revenues to hospitals will result in correspondingly lower charges and negotiated rates of payment from private payers.

Mandated coverage will also reduce the bad debts of physicians. This could also result in reduced fees, especially where fees are negotiated with limited panel plans. Two estimates are prepared, one that assumes that additional revenues resulting from payment of the bad debts of uninsured employed patients are entirely offset by lower charges to other patients, and one that assumes that none of these revenues result in lower fees to other patients.

#### *d. Reimbursement Levels*

The level of payment rates recognized or negotiated by insurers is assumed to be the same as would otherwise occur in 1993 under employer sponsored plans. In other words, providers are projected to receive the same average revenue per service as paid

currently under insurance plans, except for the impact of payment of those bad debts that would have been incurred for patients in the families of employed persons.

For traditional fee for service plans, the level of payment depends on the level of reasonable (customary and prevailing) charges that are recognized by the insurer in determining benefit payments. A lower reasonable charge screen is less expensive to the payer than one that recognizes a high proportion of physician charges.

For the cost sharing specified in the AMA Standard Benefit Plan to be that actually imposed on the insured, providers must not be able to bill for amounts higher than the maximum fees recognized by the insurers. For this to occur, either payment must be limited to providers with whom maximum fees have been negotiated or there must be a maximum fee schedule imposed by governmental authority. No assumption is made here with respect to the policy with regard to maximum fee schedules or balance billing.

For these estimates, it is assumed that (i) payment levels are the same as would occur under the types of insurers and reimbursement policies found currently and (ii) there is no balance billing. The average level of reasonable charges is thus projected to be the same as would otherwise occur in 1993 under employer sponsored plans. A policy under which insurers are free to set payment levels below actual charges and providers could collect the difference would result in lower utilization levels, since the balance billing would become additional cost sharing discouraging utilization.

For limited panel plans, whether preferred provider or exclusive, reimbursement rates are assumed to be negotiated in the same manner as at present, except that the increased levels of insurance that would be produced by mandated employer insurance would reduce the bad debts of providers and make them willing to accept correspondingly lower reimbursement rates.

#### *e. Utilization Controls*

The cost of any standard benefit plan will also depend on the processes followed to determine what is effectively covered when payment is limited to medically necessary services, i.e. services that are necessary to diagnose or treat an accident or illness, or other language to that effect.<sup>7</sup> There is a wide variety of approaches to determining what is medically necessary. These range from very limited reviews of claim submissions to proactive review of major treatment decisions of attending physicians, e.g. precertification requirements or a "nurse coordinator" present in the hospital to review medical records. An indirect means toward the same objective is to pay primary care physicians on the basis



of capitation, or with other strong financial incentives to limit care to that judged to be clearly necessary.

The assumption made in the estimates is that the distribution over approaches to determining what constitutes medically necessary services is the same on the average as would otherwise be found among employer sponsored plans in 1993.

*f. Supplemental Coverages*

The cost estimates relate to an insurance program that provides only the specific benefits included in the AMA Standard Benefit Plan. It is implicitly assumed that no employer offers a more generous plan and that none of the families purchase additional, supplemental insurance for the types of benefits included in the plan. It is thus implicitly assumed that employers that now offer first dollar "basic" plans, or that do not require cost sharing on hospital, surgery and emergency benefits, would reduce their plans accordingly. In particular, HMOs would have to offer plans with deductibles and coinsurance, which would not be possible under some federal and state laws.

These assumptions are adopted in order to illustrate the level of burden imposed by a requirement to offer the specific benefit package recommended by the AMA. They are not intended to be realistic as a projection of the conditions which a federal mandate would impose. To the extent that employers now offering plans that exceed the AMA Standard Benefit Plan continue to do so, or covered employees and their families purchase individual or franchise supplemental policies, the cost of the plan will be increased. This would occur both directly to the extent that employers paid for the additional benefits and indirectly by utilization increasing from supplemental coverage reducing the cost sharing in the AMA Standard Benefit Plan.

*g. Small Employer Access and Rate Reform*

Mandating coverage by employers requires that all employers have access to health insurance coverage. A number of states have already adopted such reforms, and many others are considering legislation that would require health insurers to accept all applicants and restrict rate variation in a manner that would end the high rate of turnover produced by current practices. It is assumed in the estimates in this report that either all states have implemented small employer access and rate reform laws similar to the NAIC model law or that the mandate is accompanied by a federal statute that accomplishes the same goals.

*h. Fully Implemented Basis*

The cost estimates relate to the average incurred cost of insurance programs in 1993 that have been in effect for long enough

that both patients and providers to have fully adjusted to the incentives provided by the plan.

#### 4. Data Sources and Methods

##### a. Establishing a Benchmark Expenditure Per Employee

The starting point for the estimates is the projection of national expenditures for health care prepared by the Office of the Actuary in the Health Care Financing Administration (HCFA).<sup>1</sup> The basis for these projections is the National Health Accounts, which document the national expenditure for each major category of health services and by each major source of funds.<sup>4</sup>

For purposes of estimating the cost of health insurance for the employed population, it is necessary to disaggregate these summary accounts in two primary ways: (i) to isolate the precise types of services that will be covered by the AMA Standard Benefit Plan and (ii) to find those expenditures that were for full time employees and their dependents covered by employer sponsored plans. In addition, any limits on the services covered or circumstances in which provided must be taken into consideration. For example, there would be no benefits for federal hospitals or for hospital stays in connection with elective plastic surgery (other than to repair damage sustained in an accident or as a result of a disease). Similarly, that portion of confinements that are for alcoholism or drug abuse that exceed 28 days in a calendar year would be excluded.

The first step is to limit consideration to covered services. The next step is to isolate those expenditures that are for the population that has employer sponsored health insurance, and that portion of these that is paid for through an employer sponsored plan. Dental and long term care benefits are also excluded, since they are not included by the AMA Standard Plan (except for certain dental surgery, which is treated as if it were performed by a physician surgeon).

The base for the estimates is the expenditures and benefits for persons covered as a result of current employment. They thus exclude any expenditures that were by retired employees, who should not illuded in estimates for the cost for a mandated plan since such coverage would not be mandatory. Also excluded are expenditures for persons eligible through workmens' compensation, since such coverage is assumed to continue as under present law. Self employed persons are not included, since these are not regarded as employed for the purposes of these estimates (although inclusion of all self employed persons as full time employees would not change the estimated average costs per employee substantially.)

This process produced the following estimates for 1993:

Expenditures by insured employed population:	\$217.8 Bil
Benefits paid for insured employed population:	181.3 Bil
Administrative costs of insurance:	25.7 Bil

The next step is to divide these by the estimated number of active employees who will hold certificates of coverage by an employer sponsored plan during 1993 (the equivalent in employer sponsored plans of the number of premium payments). This number is projected to be 68.85 million. This leads to the following per employee averages:

Expenditures by insured employed population:	\$3,163
Benefits paid for insured employed population:	2,633
Administrative costs of insurance:	373

For the reasons noted above, the number of full time employees is slightly lower than the average number of unduplicated months of full time employment by members of the relevant population. This is because some employees work more than 25 hours per week for more than one employer.

#### *b. Coverage Under Employer Sponsored Plans*

The base for the estimate of the cost to employers to cover all full time employees (which we refer to as certificate holders) is the average benefits under present law for active employees covered by employers (other than dental care). To determine the relative expense for a uniform benefit plan based on the AMA Standard Plan, an estimate of the nature of the average plan now offered by employers was required. This was accomplished in two basic steps.

In the first step, the average actuarial value of plans offered by employers was determined by calculating an actuarial value for each of the distribution of plans reported by the BLS 1988 Employee Benefits Survey, and dividing the average actuarial value of the plans by the total charges for the types of services covered by the plans. From this distribution, the average benefits for acute care services (other than dental benefits) was determined to be 83.3% of the types of acute care services generally covered by health insurance plans. The 16.7% left uncovered are only partly attributable to the explicit cost sharing in the plans. Part is attributable to less than full coverage.

#### *c. Detailed Expenditure Estimates*

The difference in expenditures under the current plans of employers and that which would occur with the AMA Standard Plan was estimated from an actuarial rate structure used to model first the average coverage of current employer sponsored plans, and then the



AMA Standard Plan. The base for the rate structure is detailed tabulations from a number of different sources. The rate structure was calibrated so that the average benefits under employer plans would equal the estimate noted above, \$2,632.50. The model was then adjusted to the benefit structure of the AMA Standard Plan under the assumption that those covered relied exclusively on this plan. The aggregate impact of the cost sharing is estimated to reduce benefits to 79.5% of the specific services covered by the plan, and 76% of all expenditures for the acute care services (other than dental care) covered by the most extensive health insurance plans.

*d. Effect of Cost Sharing*

The AMA Standard Benefit Plan provides for an annual deductible of \$350 (\$750 per family) coinsurance of 20% and with a maximum of \$1,500 in any year (\$3,000 family). We estimate that the average cost sharing for the non-prevention benefits in the AMA Standard Benefit plan would be 20.5%. Preventive care is exempt from cost sharing. This is substantially greater than the cost sharing found in the average employer sponsored plan, which we estimate to be around 12%.

The increase in cost sharing would reduce spending somewhat for the employed population presently covered by health insurance. We estimate the change that would occur using an "induced services" model, and induction parameters averaging 60%. According to this model, an increase of 1% in the proportion of medical bills paid by third parties (i.e. insurance) will increase utilization by an additional 0.6% in the relevant range. (The induction ratio is the ratio of the increase in utilization to the underlying increase in the proportion not paid by the consumer.) This model has proved reliable for estimating the impact of relatively small changes in the proportions of their medical bills that consumers must pay out of pocket.<sup>5</sup>

*e. Addition of Program of Prevention Services*

The AMA Standard Benefit Plan includes an extensive schedule of preventive services, varying by age.<sup>6</sup>

*f. Average Morbidity of the Uninsured Employed Population*

There are reasons to project that the population that is employed but uninsured will cost less to insure than those already covered by insurance:

- o The proportions of employed persons who are insured is higher in areas with a high average cost of medical care.
- o The income distribution of the uninsured employed is lower than for the insured employed.

- o The distribution by cultural and educational background is less likely to use care even when available.
- o The employment offers less time for seeking medical care.
- o The employers of the uninsured are more likely to offer only relatively low cost panels in restrictive plans.

For these reasons, the 12.6% of the population in the families of full time employed persons was assumed to spend 10% less on health care with the same access to coverage. This reduces the average cost to provide any health plan by 1.3%.

*g. Impact of Bad Debts*

The American Hospital Association Survey provides an estimate that uncompensated care constitutes approximately 6.4% of hospital costs.<sup>7</sup> Approximately 55% of the uninsured are in the families of a full time employee. The proportion of bad debts attributable to the employed uninsured, however, is somewhat less than for the unemployed. Assuming that the unemployed uninsured are 50% more likely to incur bad debts (both from higher average medical costs and lower income to pay for it), 45% of bad debts are attributable to the employed uninsured. Under the assumptions noted above, this means that the average cost of hospital services will be reduced by  $.45 \times .064 = 2.9\%$ .

Similarly, physicians are projected to agree to a fee level that produces the same net revenue per service as would otherwise occur under present law. This means that charges and fee levels agreed to under employer programs would be reduced by the extent to which payment is made for those unreimbursed services that are provided to otherwise uninsured employed persons and their dependents. The average bad debts of physicians were estimated to be 10% for this purpose, and since by the assumptions noted above 45% of them are incurred for patients in uninsured families with a full time employee, physician revenues are reduced by 4.5%.

*h. Administrative Costs*

The administrative cost of employer sponsored plans under current law are projected to be 14.2% in 1993. Further, since there are far more uninsured employees of small employers that would have high administrative expenses than those in large firms where administrative expenses are low, this would be projected to rise to 15% if coverage had been mandated by the current insurers in 1993.

Under the assumptions noted above, however, the administrative costs of small employer groups should fall substantially, reducing the average administrative expenditure from the current level of 14.2% to 12.5%.

## 5. Results

The average expenditure by employers per full time employee to offer the AMA Standard Plan is as follows:

	<u>Benefits</u>	<u>Loaded</u>
o Limited M/N inpatient care:	\$2,442	\$2,747
o Unlimited M/N stays:	2,470	2,778



## Endnotes

1. Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions", Report of U.S. Preventive Services Task Force, 1989, Williams and Wilkins.
2. The Standard Blue Cross/Blue Shield plan offered to federal employees defines medically necessary as follows. Quote from policy.
3. Burner, Sally T., Waldo, Daniel R., and McKusick, David R., "National Health Expenditure Projections Through 2030", Health Care Financing Review, 14(1), 1992, pp. 1-29.
4. Lazenby, Helen C., Levit, Katharine R., Waldo, Daniel R., Adler, Gerald S., Letsch, Suzanne J., and Cowan, Cathy A., "National Health Accounts: Lessons from the U.S. Experience", Health Care Financing Review, 13(4), 1992, pp. 89-102.
5. The RAND health insurance experiment provided the means to measure the induction parameter for relatively low proportions of cost sharing. According to the RAND data, the induction ratio of increasing cost sharing from 10% to 25% of the total expenditure would be approximately 100%, rather than the 50% assumed.
6. Clinical Preventive Services, What Works and What It Costs, prepared for the National Coordinating Committee on Clinical Preventive Services. Costs estimates from Actuarial Research Corporation, April 1993.
7. "Trends in U.S. Health Care 1990", American Medical Association, 1990, p. 139, data from The American Hospital Association.

## **American Medical Association**

### **Standard Health Care Benefits Package**

Summary of Recommendations For  
AMA Required Benefits Package

Benefit	Coverage
<p><u>A. Preventive Services</u></p>	
<p>Ages birth to 5 years</p>	<p>Thirteen physician health examinations/counseling at intervals recommended by American Academy of Pediatrics.</p> <p>Immunizations/Chemoprophylaxis: DPT; OPV; MMR; HIV; HBV.</p> <p>Tests/screening: hematology; lead; metabolic screening; urinalysis; TB and cholesterol for high risk groups.</p>
<p>Ages 6-10 years</p>	<p>Three physician health examinations/counseling at intervals recommended by American Academy of Pediatrics.</p> <p>Immunizations/chemoprophylaxis: OPV; Td</p>
<p>Ages 11-21 years</p>	<p>Yearly physician examinations/counseling as recommended in AMA Guidelines for Adolescent Preventive Services.</p> <p>Immunizations/Chemoprophylaxis: Td; HBV and MMR for high risk groups.</p>
<p>Ages 22-39</p>	<p>Tests/screening: Annual STD screening (gonorrhea, chlamydia), and pap smear if sexually active; TB, cholesterol, syphilis, HIV, HBV for high risk groups.</p> <p>Physician health examinations/counseling every 1-3 years at physician's clinical discretion.</p>
	<p>Immunizations/Chemoprophylaxis: 1 Td every 10 years; additional specific immunizations for high risk groups.</p>
	<p>Tests/screening: Cholesterol every 1-3 years; Pap smear every 3 years following 3 negative yearly findings; 1 mammogram between ages 35-39; additional specific tests for high risk groups.</p>



Benefit	Coverage
Ages 40-64	<p>Physician health examinations/counseling every 1-3 years at physician's clinical discretion</p> <p>Immunizations/Chemoprophylaxis: 1 Td every 10 years; additional specific immunizations for high risk groups.</p> <p>Tests/screening: Cholesterol every 1-3 years; Pap smear every 1-3 years; 1 mammogram every 2 years for ages 40-49 and yearly for ages 50-64; intraocular pressure measurement (IPM) yearly; fecal occult blood and digital rectal exam yearly after age 50; prostate specific antigen (PSA) every 3 years after age 50; sigmoidoscopy every 3 years after 2 yearly negative findings after age 50; additional specific tests for high risk groups.</p>
Ages 65+	<p>Physician health examinations/counseling yearly.</p> <p>Immunizations/chemoprophylaxis: 1 TD every 10 years; influenza vaccine yearly; pneumococcal vaccine; HBV for high risk groups.</p> <p>Tests/screening: cholesterol yearly until age 70, and at physician's discretion thereafter; dipstick urinalysis yearly; 1 mammogram every 2 years; IPM yearly; fecal occult blood and digital rectal exam yearly; PSA every 3 years to age 70; sigmoidoscopy every 3 years after 2 yearly negative findings to age 80; thyroid function tests yearly for women; additional specific tests for high risk groups.</p>
Pregnant Women	<p>Physician health examinations/Counseling: initial prenatal visit plus followup visits at physician's clinical discretion.</p> <p>Tests/screening: blood pressure; hemoglobin/hematocrit; ABO/Rh typing; RII (D) and other antibody screening; VDRL/RPR; HBsAg; urinalysis; gonorrhea culture; rubella antibodies; chlamydia testing at first prenatal visit. MSAFP at 14-16 weeks gestation; glucose tolerance test at 24-28 weeks; additional specific tests for high risk groups at 14-16, 24-28 and 36 weeks gestation</p>

Benefit	Coverage
<b>B. <u>Inpatient Care</u></b>	
<b><u>Hospital</u></b>	<p>Unlimited hospital days in semi-private room; ICU, operating and other treatment rooms; drugs and medical supplies/equipment; imaging, laboratory, other diagnostic tests; anesthesia; blood/blood products.</p> <p>Not covered: custodial, convalescent or domiciliary care; medically unnecessary hospitalizations.</p>
<b><u>Surgical</u></b>	<p>Surgery including pre-and post-operative care; diagnostic procedures and oral surgery; [1 specific organ transplants; anesthesia services; reconstructive surgery.</p> <p>Not covered: Radial keratotomy, cosmetic surgery.*</p>
<b><u>Medical</u></b>	<p>Medical care by attending physician, and concurrent care; consultations; imaging, laboratory and pathology services; physical therapy.</p>
<b><u>Maternity</u></b>	<p>Same hospital benefits as for illness or injury: Physician care and anesthesia services. Oral contraceptives and contraceptive devices; sterilization procedures; diagnosis/treatment of infertility.</p> <p>Not covered: in-vitro fertilization; artificial insemination; embryo transfer; reversal of voluntary sterilization.</p>
<b><u>Mental Conditions/Substance Abuse</u></b>	<p>Same hospital and physician care benefits as for other illness, except:</p> <p>Inpatient treatment for substance abuse limited to one 28-day treatment program, up to \$3,000 per lifetime.</p> <p>Not covered: Marital or educational counseling/services, halfway house services</p>

\* As defined in Policy 475.992 and in accord with AMA Policy 55.992 (AMA Policy Compendium)

Benefit	Coverage
C. <u>Outpatient Care</u>	
<u>Hospital</u>	Unlimited outpatient department admissions; imaging, laboratory and pathology services, radiation and chemotherapy, renal dialysis, and outpatient surgery including anesthesia in hospital, freestanding facility or physicians office; blood/blood products
<u>Surgical</u>	Physicians' surgical services same as under inpatient care.
<u>Medical</u>	Unlimited physician office and home visits; outpatient consultations; second surgical opinions. Physicians' services for radiation and chemotherapy, renal dialysis. Physical therapy. Family planning services. Allergy tests and injections; neurological testing.
<u>Maternity</u>	Outpatient hospital care, including birthing centers; same physician, ancillary and other services as in inpatient maternity care.
<u>Mental Conditions/Substance Abuse</u>	Unlimited outpatient therapy visits including related services and supplies; individual or group therapy provided by physician, clinical psychologist, psychiatric nurse or psychiatric social worker. Day-night hospital services.
<u>Home Health Care</u>	90 days per year of following services provided by home health agency: nursing care; physical, respiratory or inhalation therapy; prescription drugs; other medically necessary medical services or supplies.
D. <u>Emergency Care</u>	Not covered: home care for mental conditions/substance abuse; maternity, initial evaluation/monitoring; homemaker services.
E. <u>Prescription Drugs</u>	Physician services in office or outpatient department, other hospital services including related imaging and other diagnostic services, within 72 hours of accidental injury
F. <u>Dental Care</u>	Outpatient prescription drugs, including insulin
G. <u>Additional Benefits</u>	Dental services required due to accidental injury.
	Ambulance for inpatient admissions, during home health care or for accidental injury



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Benefit	Coverage
	<p><u>Durable medical equipment</u>; prostheses; prescription orthotics; cochlear implants.</p> <p>Not covered: Exercise and bathroom equipment; seat lift chairs; air conditioners and purifiers; wigs; computer devices for communication impairments.</p> <p><u>Skilled Nursing Facility</u>: up to 180 days per person per year.</p> <p>Hospice care: physician, nursing, medical social, physical therapy and home health aide services; durable medical equipment/supplies; prescription drugs. Up to 5 days hospital or inpatient hospice care.</p> <p>Not covered: Homeemaker or bereavement services.</p> <p><u>Smoking cessation treatment</u> from physician, clinic or other covered provider, one per lifetime for \$100 maximum payment.</p>

1) Limited to the following surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required.
- Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.
- Excision of exostoses of jaws and hard palate.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Reductions of dislocations and excision of temporomandibular joints.
- Removal of impacted teeth.

Chairman STARK. I really have exceeded my time and I may get a second round.

Mr. THOMAS.

Mr. THOMAS. Thank you, Mr. Chairman.

Just to make sure the record is clear, if we could start with Dr. Fried, there is no question, Congress is involved in the amount of the basic package, but the content of the package, especially when there derives a consensus that there might be a needed change in the package, is what I am focusing on, and I just need you to say one or the other, and that is, if we are dealing with the contents of the benefits package, where are each of you coming from in terms of Congress defining the content or a national board defining the content, one or the other?

Dr. FRIED. We came to suggest today that comprehensive geriatric assessment needed to be included as a part of the—

Mr. THOMAS. Ma'am, I am asking you, if you have to deal with the definition of the content of a basic package, do you believe that decisions should be left in the hands of Congress, as well as the financing? We know Congress will be doing the financing. Should the content of the benefits package be defined by a national board, some other group other than Congress?

Dr. FRIED. I would support the statement of the AMA that a board-type structure in an advisory position would provide very important information.

Mr. THOMAS. A national board.

Dr. Hoehn.

Dr. HOEHN. I would agree with the national board concept, as I stated in my testimony, because I think the professional judgment that needs to go into the decisionmaking process requires professional input. Although there are some physicians in Congress, there are not very many of them.

Mr. THOMAS. Dr. Pearson.

Dr. PEARSON. I feel that the war is too important to be left to the generals and that any decisions concerning health care ought to involve the doctors, whether it is in a consultatory basis or a national board, I think as long as we are involved.

Mr. THOMAS. Dr. Lambird, I think I know your position.

Dr. Lipkin.

Dr. LIPKIN. We would favor a national board, but think that the most decisive issue will be what the criteria for decision turn out to be, and they need to include expert and impartial assessment of medical effectiveness and an epidemiologically based approach that chooses priorities, rather than popularity.

Mr. THOMAS. Dr. Nelson.

Dr. NELSON. A national board.

Mr. THOMAS. Dr. Gulya.

Dr. GULYA. A national board working closely with Congress.

Mr. THOMAS. Thank you. The other thing that just cries out in all of your testimony, and it is probably one of the more frustrating things I have faced and we will face, is that all of you stress the importance of preventive care, early detection. Dr. Pearson, you have the dollar multipliers of various kinds of early detection and preventive care. All of you have a common cause in attacking the

current budget procedure for determining whether or not savings are made in the system.

Because as you may know, anything that involves a behavioral change of a preventive care nature can't be scored as a savings, and the problem is we are not dealing with dollars in a real world sense, and you are. You need to get the general public to understand that we should not be bound by our budget rules in dealing with health care. There needs to be a healthy component of preventive care, but we will be squeezed by the fact that is not counted as a savings in the structure. We need to get that message out.

Lastly, Dr. Hoehn, you may need to know that the administration is planning on wrapping up their internal operation by the middle of May, May 17 or so, and depending upon the legislative calendar, the President will be presenting it to I assume a joint session of Congress and the American people. If you are working on your definitions and you are going to get them to folk in about 30 days, good luck on the next round in terms of including it in the packages. People need to know that whatever your positions are need to be firmed up with an immediate response.

I assume your appeal will be to Congress, to make sure that you get on board, whatever the basis package is, and I think that is ironic, based upon all of you wanting the national board to determine it.

Thank you very much for your testimony.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Lambird, I had the opportunity to go through your benefits package, which looks to me to be quite comprehensive. I question the dollar figure of \$2,700 per individual. However, I think some of the information you show the Chairman might shed some light on that.

But as we go through the various benefits, let me just pick one out that I would like to question you about. Are you providing for any copays or deductibles or annual limits, say, on the outpatient prescription drug service you provide, which includes insulin?

Dr. LAMBIRD. Yes, sir, but I need to define that a little bit. The data that was available to us through Gordon Trapnell looked at what is actually being spent by employers for employees at this time in this country, and the data system were all captured by our data, and our data system, in fact, did have deductibles and copays.

Mr. KLECZKA. And limits?

Dr. LAMBIRD. There are no limits on benefits. This is an unlimited package in terms of dollars. There are no lifetime limits, there are no annual limits, et cetera. Now, when we put the package together, we were very conscious of cost. We looked at this in a number of different ways.

We took the data from Trapnell and basically made the decision, and all that should be clear, that these are the dollars that it costs to get the average employee in this country across America. It does not cover retirees, and that, of course, is a major problem with the auto industry, that we think that was a business decision, frankly, that was made that it was cheaper to fire somebody or retire them early and pay for their health insurance benefits, which, as you know, is a very rich package. So that is one of the reasons why the



dollars sound a little bit different. There are no retiree benefits. These are active employees. That is one problem.

Mr. KLECZKA. Do you envision a benefits package like this including those 37 million Americans who today have no insurance?

Dr. LAMBIRD. Sir, the AMA, of course, set a number of things for people who were uninsured. As you know well, 37 million is a snapshot. In fact, the Congressional Budget Office, in the little green book that the staffers all get, point out that only 9 million are underinsured over a year formula and over 2 years, so there is a real order of magnitude difference.

I even had a daughter who was uninsured briefly when she graduated from college. We have approached a number of different ways of solving the problem of the uninsured. This at the moment is an employer mandate and it takes care of that piece of it, but we have also looked at risk pools, small insurance reforms and other means of addressing the uninsured population. We would like to have everyone have access to medical care.

Mr. KLECZKA. One quick question for Dr. Gulya. Your testimony was quite informative. However, as it relates to infants born with a hearing impairment, do not pediatricians now routinely test the infant's hearing at some point in the early stages?

Dr. GULYA. Boy, I wish that were the case. I wish that were the case. That is why we are not having infants identified. In Israel, where they have a mandatory hearing screening program, the average age of infant hearing loss identification is 7 months. In Colorado and Utah, where they have the State mandated screening, the average age of hearing detection is, I believe, 7.5 months. Average age of hearing aid fitting is 9 months.

In Healthy People 2000, the Secretary of HHS put down a goal of having children identified with a hearing loss undergoing appropriate rehabilitation by the age of 12 months. We are a long way from that.

Mr. KLECZKA. Why is this not being done? Is it very costly to provide the test? I am assuming, even if it is not covered by the policy, the parent who takes the child to the doctor would ask that be done. The eyes are checked, the mouth is checked.

Dr. GULYA. Sure.

MR. KLECZKA. Why not the ears?

Dr. GULYA. Well, what we have had up to now have been relatively unreliable nonspecific, nonsensitive tests of hearing coupled with an attitude that, well, if a child isn't speaking now or doesn't seem to be hearing well, they will just try to grow out of it.

So we have an incredible need for appropriate physician education and parental education. We also now are being incredibly helped by advances in technology. The otacoustic emission testing that I talked about in my testimony is just fresh off from the research benches. It was discovered in 1978 and they have been working at developing a clinical paradigm that can have sensitivity and specificity in picking up hearing loss in noncooperative patients, which are generally infants, and that will do it.

Mr. KLECZKA. That specific test, even though it is new, what would the average cost be?

Dr. GULYA. It can be done in roughly 10 minutes for 2 ears. The training of the volunteers would be pretty minimal, because it can



be automated, and estimates up to \$25 per infant have been in the literature, so it is certainly——

Mr. KLECZKA. It's relatively inexpensive.

Dr. GULYA. It is certainly within the range of feasibility, I would think.

Mr. KLECZKA. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

Just one comment, and then I would like to ask a question of Dr. Lipkin. I think if there is anything we owe to ourselves in this health care reform debate, it is to try to be realistic. And I hope you will all listen carefully to the answer that you gave to my colleague from California about the role you want a board to play and the importance you attach to practicing physicians sitting on that board.

We have a number of boards that play important roles in the development of health care policy in America right now, and there is not a single practicing physician on those boards. That has been pointed out and yet not changed.

There is an executive branch task force health care reform effort and no practicing physicians deeply involved in that. On the congressional side, essentially no practicing physicians are involved in the development of our health care policy.

So the real question you need to ask yourselves and the real question the physician community needs to answer in America is, if the decisions are going to be made by a board on which you are not represented except indirectly, which is going to be the way it is, then what decisions do you want that board to make? Because the more you get into the competitive network model, the more you can see that we can push decisionmaking down to and back to the autonomous physician.

I would be glad to discuss this at some other time at greater length, because it isn't key to this hearing. But I think it is not good enough to say we want a board that has physicians on it, because there is nothing in reality that can indicate that you are likely to get that.

I would like to ask Dr. Lipkin, because I agree with most of what was in your testimony, and I raised this issue at other hearings as to how we are going to stimulate the production of a sufficient number of internists. After the last hearing, I got the figures on how many internal medicine and general practitioner residency slots we are not filling, and of those that we are filling, about a third are being filled with foreign students. Of those that are filled by Americans, only something like 2 percent actually go into internal medicine.

So I am struck by the fact that, while I agree with the vision of the role of the internists that you put forward, and believe it is the right role, I think your recommendations are not strong enough to assure an adequate supply of internists, and unless we do a great deal more, we can't accomplish your goals.

So I would like you to give some thought to a far more aggressive investigation of what we can do to encourage the development of the number of internists.

You are the people, according to those that I represent, who have been deeply affected by the explosion of paperwork requirements, many of them initiated by the Government. You are the people who now get a \$9 reimbursement if you visit a patient at home. So it is not good enough to say that these are much improved economic incentives to private practice, to primary care practice.

You are the people in my district who, under RBRVS, got a 20 percent reduction in your reimbursement rates, when you were supposed to get a 20 percent increase, and with global budgets and volume growing for internists, you will always be disadvantaged by the current system.

So when you look at, in a sense, the victimization of the internists by Government, by CLIA, so that you can no longer do tests that are essential to diagnosis, and you certainly can't expand your income through some lab component, by nursing home requirements that make you make irrational visits and don't reimburse you for rational visits, by rate setting that has caused you to actually have to subsidize out of your own pocket the quality of care that you think people need, and the extraordinary explosion of paperwork.

Unless we begin to look at what we did wrong in CLIA, what we did wrong in the nursing home bill regulation of a few years ago, what we did wrong in some of those laws that we have passed that make it harder to choose to be an internist or a primary care physician, then I don't think anything else we do is going to make any difference.

Yet, if we don't fulfill your vision of the role of an internist in the medical system of the future, we won't be able to provide cost-effective quality care to all of America.

You will, unfortunately, have to get back to me in writing, but maybe because the red light hasn't quite gone on, you can get a couple of words in, and if any of you want to correspond with me about this later, you are is welcome to.

Dr. LIPKIN. To respond briefly, amen. [Laughter.]

We couldn't agree more that very strong measures are needed, and unless they are taken, we won't have the infrastructure to deliver a cost-effective system. Not only that, as I said in my testimony, even if we make very substantial change immediately, the impact of that change won't begin to be seen for many, many years, because of the number of specialists out there and/or in the pipeline.

Mrs. JOHNSON. I would just comment, Dr. Nelson, in light of what I have said and he has agreed to, I was stunned at your first recommendation that we expand Medicare.

Dr. NELSON. To cover preventive services. But ASIM has just recently finished a white paper on rebuilding primary care that has 44 specific recommendations rebuilding care, many of which you touched on, and we will provide that for you.

Mrs. JOHNSON. I look forward to further correspondence.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.



Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Lambird, a couple of years ago, maybe even more now, the AMA produced a very comprehensive pay-or-play model for health care reform. You have talked in your testimony about Hawaii's employer mandate and I believe mentioned in response to one of the questions about employer mandate. Is that the AMA position still? Do you favor an employer mandate to deliver benefits?

Dr. LAMBIRD. That is the current position of the association, yes, sir.

Mr. GRANDY. And is it about 80 percent employer, 20 percent employee? I believe that is what was in the last incarnation. Or do you specify what it ought to be? Do you know?

Dr. LAMBIRD. Are we talking about—

Mr. GRANDY. The relationship between what the employer pays and what the employee pays.

Dr. LAMBIRD. The aggregate dollar figures, Mr. Grandy, that is essentially correct, with obvious limits, but that same dollar figure could go to an HMO that wish to take that sum and provide the standard benefits, so it is neutral as a—

Mr. GRANDY. Just wanted to hear you say whether or not the AMA was publicly espousing a pay-or-play or an employer mandate approach. Because I noticed in your testimony, Dr. Lipkin, you say standard benefits package should not be linked to the beneficiary's employment status. What are you advocating, then? I know you want a federally mandated package. Do you want a Federal mandate that would require everyone to carry an insurance policy that would be designed by a board or a combination between a board and a congressional approval process?

In other words, Dr. Lipkin, are you talking about an individual mandate, or did you not mean that in your testimony?

Dr. LAMBIRD. We have—

Mr. GRANDY. I was talking to Dr. Lipkin, because you said that in your—

Dr. LAMBIRD. I am sorry.

Mr. GRANDY. I am reading from page 5 of your testimony, and you say, "The standard health benefits package should not be linked to the beneficiary's employment status." I assume what you mean by that is everybody ought to have coverage, whether they work or not.

Mr. LIPKIN. That is what we mean, yes.

Mr. GRANDY. OK. Does that imply that you make some kind of a mandate on the individual, as opposed to through the employer to provide coverage? Should there be some kind of dictum in our national health policy deliberations that would require people to have some form of insurance?

Dr. LIPKIN. Yes, either people should be required either to provide insurance or to pay into a public program that provides insurance.

Mr. GRANDY. Does that mean that with religious exceptions for people who would not want to carry insurance, you would want everybody to have it?

Dr. LIPKIN. Yes.

Mr. GRANDY. And would you make that a requirement?

Dr. LIPKIN. Yes.

Mr. GRANDY. In other words, you are in violation of the law, if you don't have it, and you are subject to penalties in the Tax Code, perhaps, and things like that?

Dr. LIPKIN. Yes.

Mr. GRANDY. I just wanted to——

Mr. McDERMOTT. Would the gentleman yield for a question?

Mr. GRANDY. Could the gentleman give me his question on his time? I am trying to adhere to the Chairman's very strict dictum and making my questions short and sweet. But I would be glad to take all of the gentleman's time to answer a question.

Chairman STARK. I will recognize you.

Mr. GRANDY. I will be pleased to yield to my friend, Dr. McDermott, who is a bona fide physician, contrary to what many people have said. [Laughter.]

Mr. McDERMOTT. I only wondered if you had not heard of the single-payer system, where the government guarantees health care for everyone, rather than individuals having to go out with this——

Mr. GRANDY. I am familiar with the single-payer system.

Mr. McDERMOTT. I see. Thank you.

Mr. GRANDY. —and the all-payer system, which, as the doctor knows, is not the same thing.

Mr. THOMAS. Would the gentleman yield briefly?

Mr. GRANDY. OK.

Mr. THOMAS. My interest is that the single-payer system continues to be repeated by the single person, and perhaps if the single-payer were more than the single person, it would go somewhere.

Mr. GRANDY. Have I got any time left?

Chairman STARK. Go right ahead.

Mr. GRANDY. It is a fascinating debate, but I would like to keep the panelists involved, if I could.

This question about the mandate, though, is obviously timely and also relates to the decisionmaking entity, which is the board that you all espouse.

Let me ask you this: Is it necessary for that decision to be made by a board, or if you just denominated a value of benefit, let us say, and we are going to say that is as much as the Tax Code will allow you to forgo in terms of your health benefit deduction, and then allow competing benefit packages to go in and try to compete for those dollars, with certain limitations and guidelines?

Is it conceivable that you could have kind of uniform guidelines, but perhaps some differing benefits as you moved around different regions of the United States? Is that a workable alternative to accepting a specified benefits package, in other words, allowing a market-driven benefits package with a tax cap? Would anyone like to comment on that?

Dr. LAMBIRD. We, in effect, considered those possibilities, but we believe the standard benefits package, and the reason it got designed was to provide some guidance to Congress to, in fact, do what you have said, which is set the tax deductibility or whatever of the program.

We anticipate that the free-market system will produce a plethora of plans. We would like to be sure, so that all things are equal in competition, there is a level playing field, that this standard



benefits package be incorporated in all of them, because that is good medicine.

But we would anticipate there would be a plethora of plans providing other things that are not included in our plan, and we think this would be a highly competitive thing. What we are trying to do is level the playing field, while at the same time providing needed services.

Mr. GRANDY. I am all for that. I would just say that I see Dr. Fried at one end of the panel and Dr. Gulya at the other end. In my State, we would probably be more interested at this point in geriatric assessment, because of the high density of elderly people and the need for some kind of senior health preventive measures. If we were allowed to perhaps underwrite that benefit, we might choose that over some of the otolaryngologic things that Dr. Gulya has provided. I am just wondering if we should be allowed to do that.

Dr. Hoehn, did you want to enter into this discussion?

Dr. HOEHN. You have raised an interesting point about geographic selection. However, it depends a little bit on how wide you expand the scope of the minimum benefits package. If it is a relatively tight scope, it would probably fit in all geographic locations, and then there would be the competition for what is contained in the second, third, and fourth tiers of coverage that people might want beyond the minimum.

But I would suggest that the geriatric assessment package would probably be something that would be very beneficial in most areas of the country to be part of the minimum benefits package.

Mr. GRANDY. But at that point it is not a minimum benefits package, it is a comprehensive package and that is really what the debate is about.

Mr. Chairman, I will yield back at this time. Thank you.

Chairman STARK. Thank you.

I will thank the panel. I am sure that we will continue this discussion and debate over the rest of the year, certainly, as we work on whatever health program that we anticipate. Dr. Lambird, I look forward to the results.

One quick question: When you said the retirees were excluded, you meant the early retirees who would retire prior to qualifying for Medicare, and therefore, you didn't include the cost of filling the gap between early retirement and reaching age 65, is that it?

Dr. LAMBIRD. No, sir. Of course, as you know well, some of the employees continue to have their private insurance as a primary carrier, which is all the Medicare secondary benefit problem, but retirees are not included.

Chairman STARK. Thank you very much.

We will proceed with our next panel. The next panel will consist of Dr. Barbara Varley, who is president of the National Federation of Societies for Clinical Social Work; Dr. L. Edward Elliott, who is past president of the American Optometric Association; Dr. Walter D. Clark, president-elect of the American Podiatric Medical Association; Dr. Lowell Scott Weil, who is president of the American College of Foot and Ankle Surgeons; Ms. Beth Derby, who is president-elect of the Federated Ambulatory Surgery Association; Dr. Thomas J. O'Toole, president of the American Speech-Language-

Hearing Association; and Mr. Herbert D. Gorlin, who is president of the International Hearing Society.

Welcome to the committee. I am again going to suggest that Mr. Andrews will be chairing during this panel and he has a fast gavel. If you are cut off in midtestimony, rest assured that the members are reading your prepared testimony and will not be bashful about inquiring further at the conclusion of the panel's testimony.

Dr. Varley, would you like to begin?

**STATEMENT OF BARBARA VARLEY, D.S.W., PRESIDENT, NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC.**

Dr. VARLEY. Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to appear before you today to discuss health care reform.

I am Dr. Barbara Varley, a clinical social worker from Fresno, Calif., and currently president of the National Federation of Societies for Clinical Social Work. The National Federation represents clinical social workers throughout the United States and has formal organizations in some 33 States.

As you are aware, clinical social workers provide the majority of mental health care to our fellow citizens. The Federation has long supported national health care reform. In addition to my written testimony today, Mr. Chairman, I would ask that a short briefing paper outlining our position be included in the subcommittee's record.

While President Clinton has not yet unveiled his health care reform approach, the general thrust and of the specifics of the proposal are already known. We are pleased that mental health care will probably be included in the basic benefits package, a proposal which we have strongly endorsed for some time.

It also appears that all Americans may be asked to enter a system of managed care in order to reduce cost. Clinical social workers and our patients are already very familiar with managed care. I wish I could tell you that our experiences have been universally positive. However, in many cases, managed care systems have breached patient confidentiality and acted as a barrier to treatment, which ultimately increases the eventual cost of care. So in my few moments here, I want to share with you some examples of how managed care has worked.

Mr. Chairman, patients with mental health problems are still unfairly stigmatized, which makes the issue of patient confidentiality extremely important. Actual patient names, rather than coded numbers, are often used in telephone calls with third-party case reviewers. Reviewers frequently require detailed accounts of patients' problems as a condition for authorizing an initial interview and certainly for authorizing additional sessions.

For instance, one patient called her managed care company seeking authorizing for an initial interview. She gave her husband's name and Social Security number, since he was the employee. When the reviewer wanted details regarding her problems, she indicated she would prefer to share these with the mental health provider, since her husband was an employee of that same managed care company. In addition, her concern was that he was sexually

abusing their 12-year-old daughter. However, the reviewer refused to authorize service, unless she shared that information.

In ongoing cases, managed care reviewers frequently recommend abrupt termination, inappropriate medication, and interfere with our ability to carry out a treatment plan, and all this is often done without much clinical evaluation. These examples are some of the inherent tensions which we feel in the current system and tell us more problems are on the way.

Somehow, we need a system that must balance the need for patient centered care with the concern about cost saving. We are hopeful that, between the President and this committee, we will strike some kind of balance along those lines. We generally believe that a CHAMPUS-type program, with provision for parity amongst the professional groups, provides a model of how mental health care can be delivered without overly intrusive management.

Thank you.

[The prepared statement and attachment follow:]



**TESTIMONY OF BARBARA VARLEY**  
**National Federation of Societies for Clinical Social Work, Inc.**

The National Federation of Societies for Clinical Social Work is pleased to have this opportunity to share with the Subcommittee the views and the experiences of clinical social workers throughout the United States, as you struggle with the challenge of improving the way health care is provided and funded for all our citizens. I am Barbara Varley, President of the National Federation of Societies for Clinical Social Work.

**Clinical Social Workers As Providers Of Care**

For the benefit of those who may read the record of this hearing, and who may not be as familiar as the Committee is with the role played by clinical social workers in the nation's present health care system, let me provide a little bit of background.

Clinical social work is one of the four core mental health professions. The majority (about 60 percent) of mental health services in the United States are provided by clinical social workers. Clinical social workers practice in virtually every setting in the nation's health care delivery system -- medical and psychiatric hospitals, schools, mental health clinics, private practice, AIDS treatment facilities, managed care firms, trauma centers, research settings, the criminal justice system, and a variety of other settings. They evaluate, diagnose, and treat the full spectrum of mental and emotional disorders, including anxiety and phobic disorders, more severe illnesses such as manic depression and schizophrenic disorders, family conflicts and dysfunctions and work problems.

Clinical social workers are more likely than the other mental health professionals to provide services to the populations most at risk in our society -- the young, the poor, minorities and the elderly. We are present in the inner city and in rural areas where other providers so often are not. Our training emphasizes a bio-psycho-social approach which equips us to work with individuals, families, and communities. By training and experience it is social workers who traditionally advocate for those who cannot speak for themselves.

Mental illness and substance abuse coverage does not guarantee access to necessary services unless it is coupled with the assurance that consumers/patients are free to seek treatment from the full range of qualified providers, including clinical social workers.

**National Health Care Reform**

The National Federation of Societies for Clinical Social Work has long promoted and wholly supports the reform of the health care delivery system. We propose that a new system in whatever form should insure nondiscriminatory universal access to quality health care, recognize the need for mental health care and physical health care on an equitable basis, provide a full continuum of care based on the patient's needs and provide that at an appropriate cost level. Mental illness and substance abuse are major causes of morbidity and mortality in the United States. The personal and economic devastation caused by these illnesses is enormous. The individual, family and community all suffer from the devastation and loss. The impact on every societal institution is immense.

**The Need For Mental Health Coverage**

Mental health benefits must be provided as an integrated part of the basic health care package on an equal level with physical health care. Nearly 30 million Americans suffer from one or more mental disorders in any six-month period. Approximately one third of the adult population over 18 will suffer from a



mental illness or substance abuse disorder at some time in their lives. The statistics among our children are alarming: in 1982, 5,000 children and adolescents committed suicide, in 1985, youngsters under 18 years committed over 150 murders and over 100,000 violent crimes,<sup>1</sup> millions suffer from alcohol or drug dependence. Of the affected population, fewer than one out of five children and one out of eight adolescents receives appropriate treatment. The dollar cost of mental illness and substance abuse is staggering: \$297.4 billion in 1991, \$136.1 billion of which was for mental illness and \$161.3 billion for substance abuse.<sup>2</sup> The broader societal costs in terms of decreased productivity, unemployment, crime and incarceration, hospitalization for related causes, and the drain on welfare and social security funds can hardly be estimated.

Despite these grim statistics, many people suffering from mental illness and struggling with substance abuse fail to seek treatment. According to some statistics only 54% of those diagnosed with schizophrenia and 32% of those suffering from depression were actually treated.<sup>3</sup> The stigma attached to mental illness persists and has now been institutionalized by the way the health care delivery system is structured and the manner in which services are funded. Mental health treatment has been taken out of the mainstream in the delivery system and is reimbursed for at a rate generally much lower than that provided for physical illness. In a time of increased understanding of mental illness our definitions and delivery of services reflect a regressive movement toward viewing mental illness as a personal flaw or fault. People who do seek treatment are often penalized when they seek employment, transfer health policies or apply for disability insurance. Treatment may be delayed or neglected until the condition has worsened and has not only individual but family and community implications.

The provision of mental health and substance abuse benefits as a basic benefit will as last destigmatize the diseases of the mind and allow the treatment of the whole person.

#### Mental Health Care Is Cost Effective

Effective care for mental illness and substance abuse involves the provision of appropriate services, delivered by trained and certified practitioners in the most cost effective manner possible. A full continuum of services including preventive, outpatient, inpatient, day treatment and rehabilitative is necessary for proper medical care as well as cost effective care. Such a system offers the possibility of early intervention and the creative use of "levels of services" based on the patient's diagnosis and clinical/functional response to treatment.

Historically, mental illness was paid for on a fee for service basis. When the cost of care throughout the medical system escalated, the third party entered the scene. People wanted protection for catastrophic treatment and insurers responded by writing policies that reimbursed at the highest levels for hospitalization. Although in some cases outpatient coverage increased, the system encouraged hospitalization. Mandated coverage laws were passed in a number of states dictating the provision of mental health benefits and levels of care. Within the last ten years, however, those benefits have eroded with the advent of managed care systems that fall outside state laws.

The attack on mental health costs has occurred during the frightening escalation of total health care costs. Some imply that the cost of treating mental illness has been disproportionate to other health costs and that the treatment of emotional illness is less necessary than that of physical illness. This perception is not only short sighted but misinformed. The cost of treating mental illness has indeed increased just as have other health care

costs. However, there has not been an increase in the proportion of the health care dollar apportioned to mental illness; the cost has remained at about 8 cents of the health care dollar, approximately 10 cents when substance abuse is included. Approximately 2% of the total is expended for outpatient care.<sup>4</sup> In fact, the percentage of the health care dollar expended for treating mental illness and substance abuse has varied little in the past 20 years no matter what delivery and/or reimbursement system is used.<sup>5</sup>

Numerous studies are now validating what clinicians intuitively knew. Timely and appropriate mental health and substance abuse treatment shortens the duration of treatment, diminishes the damage done to the individual and society and reduces other health care costs.

Studies conducted in the mid 80's by Aetna and Blue Cross reveal shorter hospital stays of medical/surgical patients who were provided modest psychological support and lower utilization of medical surgical services in those treated in brief outpatient psychotherapy. Companies which have experimented with increased outpatient coverage have found their overall health care costs decrease. Campbell Soup offered 100% coverage for the first 10 days of inpatient psychiatric care and 80% thereafter, but covered only 50% of each outpatient visit. When they increased the outpatient coverage to 80% per visit, the overall costs for mental health and substance abuse decreased 28%. Union Carbide's original benefit program provided 100% coverage for inpatient psychiatric and substance abuse care, but only 80% for outpatient care. When they changed their policy to add 100% outpatient coverage of as much as \$5,000 and 80% thereafter, their total health care costs decreased "from double digits to single digits". Both companies boast better than 90% satisfaction rates among their users.<sup>6</sup>

An analysis of 58 cost-offset studies reported an 85% decrease in medical utilization following psychotherapy. The analysis reviewed 6.7 million Blue Cross/Blue Shield cases comparing medical utilization among mental health treatment users and non-users. Although patients receiving outpatient mental health care had higher initial overall health care costs, their changes leveled off and became lower in every subsequent year. Those over age 55, one of the most rapidly growing age groups in the United States, showed the most dramatic decline in hospital charges.<sup>7</sup>

Given the phenomenon of utilization constancy, modest cost increase and medical cost offset savings when mental health benefits are provided, there is little necessity to micro-manage the benefits. Ironically, however, the managed care emphasis has been on mental health with managed care companies proliferating at a speed that defies the imagination. Their presence discourages treatment, intrudes on the treatment process, invades patient confidentiality and diverts funds that would otherwise be devoted to patient care. There is increasing evidence that the managed care bureaucracy with its paperwork, phone calls, reviews, marketing, competitiveness, etc., is costing not saving money. A chaotic atmosphere has been created which is costly in human and economic terms.

We would propose the restoration of balance in a new health care delivery system. Research shows us that most people who utilize their mental health benefits do so moderately. For instance, a sample of 17,900 persons from a survey of annual use of outpatient health care revealed that only 4.3% of the sample reported one or more mental health visits. The average number of visits per year of that sample was 8.2. Eighty-five percent of those who used the benefit used less than 15 visits per year. Less than 10% made 25 or more visits and accounted for 50% of mental health expenditures. Of these, at least one third had multiple health problems as well as their mental health conditions.<sup>8</sup>

This configuration is born out by numerous other studies and suggests clearly that early stage treatment reviews are an unnecessary expenditure. A review system, like that used in the Champus Program, which begins at the 24th visit, is more appropriate and cost effective. Standardized forms and procedures throughout all plans would also facilitate the process, as would standardized fees for each mode of treatment, regardless of the provider's profession.

### Quality Of Care

Quality mental health care will result from the combination of highly trained, licensed mental health and substance abuse providers working within a health care delivery system that protects the consumer's rights and provides appropriate services.

Quality care is patient-centered care, informed by a clinical assessment and diagnoses, and devised to meet the patient's needs in terms of the focus of treatment, the modality of treatment and the duration of treatment. Progress and outcome are functionally measured. The existence of inpatient, day treatment and outpatient facilities allows flexibility in treatment planning. In such a system individual rates of recovery and psycho-social factors can be considered. The patient's right to be treated in the least restrictive and usually the least costly environment is preserved and confidentiality vigorously protected.

It is essential that the system devised allows easy access to care and freedom of choice among trained and certified providers. Preservation of therapeutic relationship, once established, is paramount since the relationship between patient and therapist is the vehicle for treatment. The current managed care system often results in inaccessibility to treatment or disruption of care by virtue of "pre-existing condition" clauses, job change or loss and/or change of insurance coverage by an employer. Any or all of these circumstances can prevent or disrupt therapy with devastating results.

There must be special consideration of the needs of children and adolescents. The problems of these age groups differ significantly from adults and must have separate protocols for diagnosis and treatment. The benefit structure must provide for the collateral work with parents, teachers, etc., that is crucial for success with children.

Today's managed care environment is geared toward cost reduction, not quality care. Outpatient treatment is reduced based on the faulty assumption that mental health services are "discretionary". Needed care is denied by limiting providers, establishing financial disincentives for treatment, and requiring pre-certification. Reviews required by managed care intrude into the provider/patient relationship requiring the divulgence of confidential information to justify treatment and can have an adverse effect on treatment progress. Reviews also target long term care, thereby limiting services to many most in need of those services. Benefit decisions should be based on the severity of the patient's illness, his/her rate of recovery, and environmental stresses - not solely on perceived cost savings. Procedures should be responsive to critical emergency situations so that the patient does not remain at risk due to administrative procedures.

In order to assure quality care, cost containment measures should be based on sound therapeutic standards and practices which have evolved in the mental health professions rather than be based on a minimalist approach which encourages recidivism and disregard for professional judgment. Ethical utilization review is possible only when conducted independent of the insurer's profit motive and



only by reviewers who are experienced licensed mental health practitioners with specialized training in assessment and review.

### Regulation And Accountability

The nation's health delivery system must be nationally regulated. The current market approach has been a disaster creating unbelievable chaos, cost escalation, denial of care and a discriminatory two level system. The current form of managed care has magnified the problems with its discriminatory practices and has created a burden on the public system where the long term mentally ill are being dumped.

A new delivery system must contain a basic benefit package which includes mental health. Each entity within it (HMO, IPA, indemnity plan) must offer the same basic package to prevent the skimming of the system and the shifting of the seriously ill to the Indemnity plan and the public mental health clinics.

As a profession, clinical social workers support the notion of accountability of both the provider and the insurer. Currently, only the provider is held accountable while health maintenance organizations and managed care activities fall outside state and federal regulation. An ethical dilemma is created for the provider when treatment is indicated, the insurer denies benefits and the patient is without ability to pay. Patient abandonment is an unacceptable solution. The system as a whole must comply with state and federal regulations without exemption. Benefits must be clearly stated. Criteria and interpretive guidelines used for determining access to treatment and/or denying it should be publicly disclosed. Those in the position of reviewing and denying care must be held accountable for adverse benefit decisions and procedures through state and federal regulations. An appeals process must be structured that is clear, fair and efficient.

A research component should be built into a new system. Within it a cost/benefit analysis should not only consider clinical outcome and cost of treatment, but also societal costs. The current system has not been informed by such data. Monetary expenditure has been the major focus resulting in an often biased and regressive approach to treatment. As a result, our knowledge of the mind and the techniques to treat its ills becomes more sophisticated and the funding necessary to use that knowledge decreases.

Quality assurance cannot be left to the delivery system itself. An apparatus for independent review must exist. In the existing managed care system the third party payer is also the reviewer. This creates a built in conflict of interest. The entity which exists to contain costs and whose profits are decreased by cost over runs, cannot be expected to keep the welfare of the patient firmly in mind. The review system must stand independently of the payer and provider. Those entrusted with such serious and far reaching decisions must be well qualified professionals with specific training in review. We would recommend that peer review be a key component of the review system.

We commend the Subcommittee for its efforts to reform our national health care system. Because the Administration has not yet unveiled its proposal, we cannot address today the specific issues that are likely to be posed once the design of the Administration's proposed plan is known. The clinical social work profession would welcome the opportunity to provide further input to this Committee as the process goes forward and specific legislative proposals are under consideration. In the meantime, if you would like further information about the experience of clinical social workers in the past and current health care delivery systems, including the abuses experienced by our patients in dealing with today's version of managed care, please do not



hesitate to contact me or our Washington Representatives, John Dill and Leslie Bryan.

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## HEALTH CARE REFORM POSITION PAPER FROM THE NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

### Executive Summary

Any program of national health care reform must be cost-effective, provide universal access, and insure high quality diagnosis, treatment and prevention for both physical and mental illness. A continued role for clinical social workers, who currently provide 65 percent of outpatient mental health services in the United States, and who do so in a cost-effective manner, forms part of the solution to our national health care crisis. An adequate mental health benefit must be part of any basic health care package. And people who need mental health diagnosis and treatment services must have freedom of choice among all qualified providers, including clinical social workers.

### Clinical Social Workers: Who They Are and What They Do

The majority of mental health services in the United States is provided by clinical social workers. Clinical social workers practice in virtually every setting in the nation's health care delivery system, e.g. medical and psychiatric hospitals, schools, mental health clinics, private practice, AIDS treatment facilities, managed care firms, trauma centers, research settings, the criminal justice system and a variety of other settings. They evaluate, diagnose and treat the full spectrum of mental and emotional disorders -- ranging from family conflicts and dysfunctions, to work problems, to anxiety and phobic disorders, to more severe illnesses such as manic-depression and schizophrenic disorders.

Clinical social workers are also known to provide access, to mental health services to underserved populations such as the elderly, minorities and in rural areas where there are often no other providers

### Clinical Social Workers: Their Education and Qualifications

Clinical social workers have completed a two-year master's degree at a school accredited by the Council on Social Work Education, or a doctoral degree, with a concentration in clinical social work. Their training includes at least one year-long supervised field placement in a clinical social work setting, plus at least two years of post-master's supervised clinical practice before beginning independent practice. Currently, all 50 states and the District of Columbia have passed laws regulating the credentialing of clinical social workers.

### The Need for Mental Health Coverage

Mental illness in the United States is widespread. According to the National Institute of Mental Health (NIMH), nearly 30 million Americans suffer from one or more mental disorders in any six month period, and approximately one-third of

adults over age 18 will suffer from a mental or substance abuse disorder at some time in their lives.

Conservative estimates indicate that approximately 12 percent of our nation's children (nearly 8 million) under the age of 18 need treatment for a mental disorder. Fewer than one out of five children, and only one out of eight adolescents, are receiving appropriate treatment. By 1986, suicide was a leading cause of death in the 15-18 year old age group.

Despite these grim statistics, persons suffering from mental illness continue to be stigmatized for these disorders, often reluctant to seek access to needed services. There is still widespread belief that only "crazy" people seek psychotherapy from mental health practitioners. Indeed, seeking treatment may stigmatize people when applying for employment, or health, disability or life insurance. Treatment may be delayed or neglected until the condition is quite severe and is then felt not only by the child and family, but by school or law enforcement agencies. Early intervention usually means treatment is simpler and shorter, and therefore more cost-effective.

### Mental Health Care is Cost-Effective

In the past, most health care reform proposals have responded to increased health care costs by cutting back on mental health benefits, implying that the direct cost of treating mental illness is too high. This response is short-sighted and counterproductive. It has been well-documented that mental disorders, left untreated, often lead to physical illnesses requiring more costly medical care. In addition, there are indirect costs of untreated mental health problems. Only 36 percent of students with serious emotional disorders graduate from high school. There are more Americans with serious mental illness in prisons and street shelters than in hospitals. American business loses over \$100 billion per year due to lost productivity of employees because of mental illness and substance abuse disorders. When the costs of lost employment, lost work productivity, vehicular accidents, criminal activity and social welfare programs are considered, indirect costs are estimated to be \$250 billion. Mortality costs from premature death due to mental disorders are estimated at \$11.7 billion annually. Total mortality losses for alcoholism and drug abuse are estimated at \$33.6 billion. While these dollar amounts are staggering, the costs in human suffering and tragedy cannot be estimated in dollar amounts.

### The Current Role of Clinical Social Workers

Mental health coverage alone does not guarantee access to needed services unless it is coupled with an assurance that consumers are free to seek treatment from a range of qualified

providers, including clinical social workers. As the largest group of mental health professionals in the U.S., clinical social workers currently provide most of the country's outpatient mental health care and have achieved wide recognition in both the public and private insurance sectors. Currently, 26 states and jurisdictions require group insurance plans to reimburse clinical social workers for the provision of covered mental health services, and all the major federal insurance programs -- Medicare, CHAMPUS and the Federal Employees Health Benefits Program -- include clinical social workers as authorized providers of covered services. This level of acceptance and support for clinical social workers in the mental health field should guarantee their inclusion in any national proposal to provide universal access.

### Clinical Social Workers And National Health Care Reform

As the Administration and Congress grapple with reform of the current national health care system, the National Federation urges federal policy makers to retain those portions of the current system that have worked well.

Specifically, any reform proposal must include an adequate mental health benefit as part of the basic, standard health care package. That benefit should be provided on the same basis as physical health benefits. There should be no artificial limitation on outpatient visits, comparable co-payment requirements, and universal access to the mental health providers of an individual's choice. Pre-existing conditions that exclude mental health coverage should be eliminated.

#### A. Clinical Social Workers and Managed Care

Clinical social workers play a vital role in managed care. Clinical social workers combine direct treatment competence with a skill in accessing other community resources in the interests of good overall biopsychosocial health of their clients. Their skills are highly compatible with managed care, and their wide utilization within managed care supports this view. According to a survey published by Interstudy in 1992, HMO mental health staffs throughout the country include more clinical social workers than any other provider discipline. Mental health preferred provider organizations (PPO's), which reduce costs by matching client need to the most appropriate provider, also rely heavily on clinical social workers to furnish quality care at a reasonable cost. This access must be preserved under any health care reform proposal.

#### B. Clinical Social Workers and Managed Competition

One of the attributes of a managed competition approach is its reliance on large integrated service networks (ISN's) that will compete with each other for a community's health care



business. To be effective in containing costs while preserving quality care, ISN's must preserve patient access to providers from all major mental health disciplines, including clinical social work. This means eradicating not only discriminatory benefit provisions but also any discriminatory restrictions on access. All disciplines of qualified providers (mental health and physical health alike) must be given opportunities to participate in ISN's on the same basis as any other provider. Further, any limitation on participation in ISN's is likely to result in a "bottleneck," which would unnecessarily interfere with access to prompt mental health care treatment.

#### C. "Pre-existing" Treatment Problem

A danger of managed competition, premised as it is on the development of competing provider networks, is that it may force individuals with chronic mental illnesses requiring treatment and/or management over a multi-year period to switch providers with every new contract period. Because of the great importance of the treatment relationship in mental health, and its frequent fragility due to the nature and severity of the illnesses being treated, the managed competition approach has a potential for severe disruption of patient care. This potential is a problem for anyone with a chronic disorder, but is especially dangerous for the mentally ill. Any new health care system should be designed so as to safeguard and preserve existing provider-patient relationships and to avoid needless disruption of care.

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Mr. ANDREWS [presiding]. Thank you.  
Dr. Elliott.

**STATEMENT OF L. EDWARD ELLIOTT, O.D., PAST PRESIDENT,  
AMERICAN OPTOMETRIC ASSOCIATION**

Dr. ELLIOTT. Thank you, Mr. Chairman.

I am Ed Elliott, doctor of optometry, from Modesto, Calif., and immediate past president of the American Optometric Association.

On behalf of the Nation's 28,000 practicing optometrists, I commend you for holding this hearing on the important issue of what should go into a benefits package under health care reform, and I thank you for the opportunity to present our views. You have my written statement, and so to stay in the green, I would like to briefly summarize our points.

First, any benefits package should clearly cover symptom-related visits for acute problems, including eye health problems. The model for this coverage already exists at the Federal level with the Medicare program.

In addition, to assure early diagnosis of potentially costly and debilitating eye and systemic diseases, periodic preventive eye and vision examinations should also be included in the package. At the very minimum, we believe it makes sense to include preventive services for all children, the model being those services currently provided under the early and periodic screening diagnosis and treatment program, EPSDT. The long-term savings to the health care system by early diagnosis of costly eye and systemic diseases will more than offset the costs of providing this preventive care.

Finally, Mr. Chairman, patients in whatever type of plan that emerges from this debate should have access to all provider groups licensed to provide covered services, the same as provided for physician services in the Medicare program. In fact, the demographics and practice patterns of eye care providers dictates that, without such parity in provider coverage, a severe access problem will be created in many parts of the country.

Mr. Chairman, vision and eye health problems are one of the most prevalent health care problems in our country, affecting more than 120 million people, with children and the elderly being at the highest risk. We believe a combination of symptom-related and preventive eye and vision coverage in a basic benefits package makes good sense for the long-term health of our Nation.

Again, I thank you for the opportunity to testify on this important issue and would be happy to answer any questions.

[The prepared statement follows:]

## TESTIMONY OF L. EDWARD ELLIOTT American Optometric Association

Mr. Chairman, I am Ed Elliott, doctor of optometry, from Modesto, California. I appreciate the opportunity to testify before the Subcommittee again and I commend the Chairman for holding hearings on an issue that will be one of the most important in the health care reform debate.

I am in private practice in Modesto and also teach at the University of California at the Berkeley School of Optometry. I am the past president of the American Optometric Association (AOA) which represents the largest eye care profession in the nation with approximately 28,000 optometrists in practice. As an organization representing the providers of the majority of primary eye care services in the nation, we welcome the opportunity to discuss the benefits that should be included in a comprehensive health benefits package.

Before outlining what I think should be included in a benefits package under any national health care reform proposal, I would like to point out what an important role eye care plays in the health care system, how optometry fits into the health care system, and what services optometrists can provide.

### NEED FOR EYE CARE

Vision and eye health problems are the second most prevalent, chronic, health care problems in the U.S. population, affecting more than 120 million people. Undetected and untreated, they reduce the educability of the child, hasten senility in the elderly and contribute to the social isolation of the individual. Early detection and appropriate treatment are essential to preserve performance and prevent damage and consequent handicaps which can result from neglect. The two age groups at highest risk for vision problems are children and the elderly.

#### Children

Children are at high risk because of the impact of uncorrected vision handicaps on their educational and developmental progress, including visual and perceptual skills for language and learning. Since most vision problems occur without pain, they may be completely unknown to parents, teachers or even the child. The behavioral changes caused by undetected vision problems in children are erroneously attributed to other unrelated causes, such as mental retardation or attention deficit disorder. Early diagnosis and treatment can aid in preventing or correcting vision conditions which can interfere with a child's learning and self image.

#### Elderly

The elderly, too, are at risk because of physiological changes which come with age. The elderly develop increasing incidence of systemic disease and a decline of sensory function. Vision and eye health problems increase significantly in frequency and severity with age and are more prevalent in those over 60. With the reduction in vision in the elderly, many times comes the increase in dependency. Thus, by providing eye care to the elderly, many times an independent life style can be maintained.

### OPTOMETRY'S ROLE

For many people, an eye examination is the entry point into the health care system since many Americans who postpone or avoid other forms of health care often continue to seek eye care. Over 60 percent of the primary eye care examinations in this country are performed by optometrists. In a typical state, nearly two-thirds of all available eye care specialists are doctors of optometry.

Optometrists are the most accessible of eye care providers, serving in more than 6,800 municipalities throughout the United States. In more than 4,000 of these communities, optometrists are the only primary eye care providers.

While approximately 70 percent of optometrists are in private practice settings, many others practice in multidisciplinary group practices, in hospitals, with the Veterans Administration, Public Health Service, and the Armed Services. Other optometrists participate in managed care plans such as HMOs, preferred provider organizations, and independent practice associations. In many of these organizations optometrists function as the entry point into the system for eye care.



As primary care providers, optometrists are an integral part of the health care team. They are specifically trained to diagnose, manage, and treat conditions and diseases of the human eye and visual system. As an entry point into the health care system, optometrists are positioned to serve a prevention role as an effective source of triage for not only eye health problems, but systemic health problems with eye manifestations as well.

### ACCESSIBILITY

Because of their geographical distribution, optometrists provide services to patients that they may not have access to otherwise. This is especially true in rural areas. In many areas, an optometrist may be the only eye care provider available. In communities where there are no other eye care practitioners, a patient may do without eye care, travel long distances for eye care, or incur out of pocket expenses to visit his or her optometrist if optometric care is not specifically included in the plan. By including optometrists in any health care reform package that is enacted, money can be saved for both the patient and the health care system by reducing patient out of pocket travel expenses, additional visits to the doctor, and valuable time away from work for both employers and employees.

Low income patients, often at high health risk, are very dependent on optometrists for their primary eye care services. In Oregon, a 1991 report found that over two-thirds of the care rendered to this high health risk population was provided by doctors of optometry. Historically, as a profession, optometrists have demonstrated a high participation rate in government programs serving disadvantaged communities.

### COST EFFECTIVENESS

Besides being accessible, optometrists are also cost effective. Office fees and charges for visits associated with the treatment of eye diseases are on average lower for an optometrist than an ophthalmologist. National and regional surveys of professional fees and analysis of public health programs present significant evidence of the lower cost of eye care when provided by optometrists.

Managed care entities, such as health maintenance organizations, recognize the potential cost savings of optometrists. InterStudy, a nationally recognized research firm, documented a potential 36 percent savings when optometric manpower was utilized to the full extent of their training and competence. "The most cost effective models are those where optometrists perform all routine examinations and also manage certain eye diseases and conditions." A report published by the Group Health Association of America documents the cost control benefit of using optometrists as primary care providers in integrated managed care networks.

### COMPREHENSIVE EYE CARE BENEFITS PACKAGE

Having described eye care and optometry's role in the health care system, I would like to outline what the American Optometric Association feels should be included in any comprehensive eye care benefits package. A comprehensive benefits package should include two components -- regular periodic preventive care for all age groups, and the more symptom-related diagnostic and treatment services currently covered under the Medicare program. At a minimum, the package should include preventive services for children along the lines of those provided under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). In addition, the package should continue to provide ophthalmic materials for the Medicaid population.

#### Preventive

To assure early diagnosis of potentially costly and debilitating eye and systemic diseases, preventive eye examinations should be scheduled as follows:

From birth to six years of age there are three critical periods in which examinations should be given. Every infant should be entitled to an eye/vision screening between 4 and 9 months by an eye care practitioner. If the infant fails to pass this screening, a full eye examination should be given. Every child should be entitled to an eye/vision screening between 30 and 42 months of age by an eye care practitioner. If a child fails to pass this screening, a complete eye examination should be completed. It is imperative that every school age child, usually age 5 or 6, receive a full eye exam before entering school to insure that they will be able to function in the classroom.

Individuals between the ages of 7 and 60 should get eye examinations every two years. Over the age of 60, individuals should have yearly eye examinations. In addition to this schedule, high risk groups, such as diabetics, should be seen on a more frequent basis. For example, the Centers for Disease Control recommends that all patients with diabetes mellitus should have a yearly eye examination.

#### Symptom-Related

As part of the second component of the comprehensive benefits package, symptom-related services should be covered. Vision and eye care diagnostic and treatment services currently covered under the Medicare program should be a covered service for all individuals. This would mean that the eye health part of an examination would be covered when the patient had a symptom, condition or complaint that necessitated the visit.

#### CONCLUSION

Ultimately, eye care and optometry should be included in any comprehensive benefits package that is enacted by Congress. Only by including eye care in health care reform can the visual welfare and eye health of our communities be preserved. It has been shown that for children to progress educationally, and the elderly to function independently, preventive eye care needs to be provided. In addition to preventive eye care, symptomatic care also needs to be provided as is presently covered under Medicare.

Optometry wants to be a part of the solution in reforming the health care system. Optometric care is accessible, affordable and represents an efficient component of the health care delivery system. Patients in all plans covering eye care should have the right to an eye practitioner of their choice, either an optometrist or ophthalmologist, the same as provided for in the Medicare program. In fact, the demographics of eye care providers dictates that without such parity in provider coverage, a severe access problem will be created in many parts of the country. Including optometry in the health care system will assure the goal of providing affordable, quality eye care to all Americans.

Again, I thank the Chairman for allowing me to testify on this critical issue and welcome any questions that you might have.

Mr. ANDREWS. Thank you.  
Next we will have Dr. Walter Clark.

**STATEMENT OF WALTER D. CLARK, D.P.M., PRESIDENT-ELECT,  
AMERICAN PODIATRIC MEDICAL ASSOCIATION, INC.**

Dr. CLARK. Thank you, Mr. Chairman.

I am Dr. Walter Clark, the president-elect of the American Podiatric Medical Association, and a private practicing podiatric physician in Birmingham, Ala.

I very much appreciate this opportunity to appear and testify on the broad subject of health care reform, as well as the more specific topic of what should constitute a standard or uniform health benefits package for all Americans.

Before addressing specifically the issue of this hearing, I want to address concern about a related matter, namely, whether or not the Congress or a national health board should determine the benefits package.

In my association's judgment, the responsibility clearly belongs here with the U.S. Congress. It further believes any comprehensive benefits package should be specified in the legislation. Under managed competition, a national health board could serve many valuable administrative functions, but the benefits package we feel should be legislatively prescribed.

With regard to that standard benefits package under health care reform, several criteria guide our thinking. The package should be comprehensive, offer choices to the beneficiaries, be affordable and promote uniformity.

Furthermore, it is critical that shared responsibilities characterize any such benefits program.

The baseline for a comprehensive benefits package could be either Medicare parts A and B, or presently constituted in the HMO Act of 1973. Both programs have been tried and tested over many years, and we see no reason why to try and reinvent the wheel. Either could be the baseline for a standard benefits package, even though a Medicare model would probably require a stronger commitment to prevention than is currently the case.

Though it is possible and desirable to craft a standard benefits package which guarantees to one and all a basic level of coverage, the package should not be so rigid that flexibility in benefits design is lost. Employers need to be able to offer their employees multiple benefits packages, as long as the basic level of coverage is guaranteed to all citizens.

This leads me, Mr. Chairman, to an important, though controversial subject. In our judgment, though we are not health care financing experts, shared responsibility must be borne by those who select plans which exceed the basic benefits package. This burden must be shared by employees, not their employers alone. The parameters for such shared responsibility are a decision for the Congress to make, and it will not be an easy one. Coverage must be affordable for one and all and shared financial responsibility should not be so severe, that needed care is neglected.

Also, Mr. Chairman, we strongly urge that uniformity guide the reform process. Our experience over the past 25 years in a variety of Federal health programs prompts this recommendation. Whether



the program has been Medicare, Medicaid, CHAMPUS, Federal Employee Compensation, Federal Employees Health Benefits or a variety of other initiatives, uniformity in the program design and implementation have been seriously—and I underline “seriously”—lacking.

Not only do benefit designs specifically vary, the claims development process can make one’s head spin. Also, it is a fact that important terms are defined differently by these various programs. This is unfortunate, indeed unnecessary, and we hope the reform process will serve to address these program flaws.

Finally, Mr. Chairman, I wish to dwell on one remaining issue. Presently, 42 States have enacted freedom of choice statutes affecting doctors of podiatric medicine. These State laws impact on indemnity health care plans by requiring them to cover the services of podiatrists, if those same plans provide coverage for foot and ankle care. These State laws have been very important, if for no other reason, they have brought competition to the marketplace.

As you know, a variety of health care reform scenarios propose a Federal preemption of State mandated benefits laws, including preemption of freedom of choice of particular practitioner statutes. We lament these attacks on the freedom of choice laws, since these statutes do not mandate new or expanded benefits. They merely assure consumers a choice of practitioners to treat an already covered benefit. As far as the injured or diseased foot is concerned, it has been and continues to be a covered benefit in all third-party plans, public or private. Under health care reform, we assume this trend will continue in an uninterrupted fashion.

But if reform brings about the preemption of State freedom of choice laws, we strongly feel such a move could be counterproductive to any health care competitive process. To avoid such adverse consequences, we urge that the Federal statute be explicit in authorizing licensed health care professionals, including doctors of podiatric medicine, to compete and participate in the process.

Thank you, Mr. Chairman, for this opportunity to present our views, and I will be pleased to answer any questions of the committee.

[The prepared statement follows:]

**TESTIMONY OF WALTER D. CLARK**  
**American Podiatric Medical Association, Inc.**

Mr. Chairman, members of the Subcommittee:

I am Dr. Walter D. Clark, President-Elect, American Podiatric Medical Association, and a private practicing podiatric physician in Birmingham, Alabama. I very much appreciate this opportunity to appear and testify on the broad subject of health care reform, as well as the more specific topic of what should constitute a standard or uniform health benefits package for all Americans. Indeed, health care reform has necessarily captured center stage in both the Congress and the Administration. And the chances are much better than even that, before the 103rd Congress concludes its business, a reform measure of sorts will be forwarded to the President for his signature.

If measured only in terms of the Nation's staggering debt and its nearly \$1 billion per day deficit spending, it appears unrealistic to assume that comprehensive reform can transpire in the near future. Yet something must happen if only to address the needs of the Nation's thirty four million plus uninsured and underinsured. From what we read and observe, some form of managed competition will likely characterize the eventual reform package. Designing and implementing this untried, untested approach is both a challenging and formidable task, one which will test budget neutrality like its never been tested before!

- National Health Board -

Before addressing specifically the issue of this hearing, I want to express concern about a related matter, namely, whether or not the Congress or a National Health Board should determine the benefit package. In the association's judgment, that responsibility belongs right here and, it further believes, any comprehensive benefit package should be specified in legislation. Under managed competition, a National Health Board could serve many valuable administrative functions; but the benefit package, I feel, should be legislatively prescribed.

- Standard Benefit Package-

With regard to a standard benefit package under health care reform, several criteria guide our thinking. The package should be comprehensive, offer choices to beneficiaries, be affordable, and promote uniformity. Furthermore, it is critical that shared responsibility characterize any such benefit package.

The baseline for a comprehensive benefit package could be either Medicare, Parts A and B, or that presently constituted in the HMO Act of 1973. Both programs have been tried and tested over many years, and we see no reason to try to reinvent the wheel. Either could be the baseline for a standard benefit package even though a Medicare model would probably require a stronger commitment to prevention than is currently the case.

Though it is possible and desirable to craft a standard benefit package which guarantees to one and all a basic level of coverage, the package should not be so rigid that flexibility in benefit designs is lost. Employers need to be able to offer their employees multiple benefit packages as long as the basic level of coverage is guaranteed to all citizens.

This leads me, Mr. Chairman, to an important, though controversial, subject. In our judgment, though we are not health care financing experts, shared responsibility must be borne by those who select plans which exceed a basic benefit package. This burden must be shared by employees, not their employers alone. The parameters for such shared responsibility are a decision for the Congress to make, and it is not an easy one. Coverage must be affordable for one and all, and shared financial responsibility should not be so severe that needed care is neglected.

Also, Mr. Chairman, we strongly urge that uniformity guide

the reform process. Our experience over the past twenty-five years in a variety of federal health programs prompts this recommendation. Whether the programs have been Medicare, Medicaid, CHAMPUS, Federal Employee Compensation, Federal Employees Health Benefits, or a variety of other initiatives, uniformity in program design and implementation have been seriously lacking.

Not only do benefit designs significantly vary, the claims development process can make one's head spin. Also, it is a fact that important terms are defined differently by these various programs. This is unfortunate, indeed unnecessary, and we hope the reform process will serve to address these program flaws.

- Conclusion-

Finally, Mr. Chairman, I wish to dwell on one remaining issue.

Presently, forty two states have enacted freedom of choice statutes affecting doctors of podiatric medicine. These state laws impact on indemnity health care plans by requiring them to cover the services of podiatrists if those same plans provide coverage for foot and ankle care. These state laws have been very important, if for no other reason than they have brought competition to the marketplace.

As you know, a variety of health care reform scenarios propose a Federal preemption of state mandated benefit laws, including preemption of freedom of choice of practitioner statutes. We lament these attacks on freedom of choice laws, since these statutes do not mandate new or expanded benefits. They merely assure consumers a choice of practitioners to treat an already covered benefit. As far as the injured or diseased foot is concerned, it has been and continues to be a covered benefit in all third party plans, public or private. Under health care reform, we assume this trend will continue in an uninterrupted fashion.

But if reform brings about the preemption of state freedom of choice laws, we strongly feel such a move could be counterproductive to any health care competitive process. To avoid such adverse consequences, we urge that the federal statute be explicit in authorizing licensed health care professionals, including doctors of podiatric medicine, to compete and participate in the process.

Thank you, Mr. Chairman, for this opportunity to present our views. We would be pleased to respond to any questions you might have.



Mr. ANDREWS. Thank you.  
Our next witness will be Dr. Lowell Scott Weil.

**STATEMENT OF LOWELL SCOTT WEIL, D.P.M., PRESIDENT,  
AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS**

Dr. WEIL. Mr. Chairman and members of the subcommittee, my name is Dr. Lowell Scott Weil, and I practice podiatric medicine and surgery in Des Plaines, Ill. Currently, I am president of the American College of Foot and Ankle Surgeons. On behalf of more than 3,400 members of the college, I am pleased to have the opportunity to present testimony on the basic benefit structure to be contained in the health care reform legislation that we expect will be enacted during this Congress.

Let me echo the statements of Dr. Walter D. Clark, president-elect of the American Podiatric Medical Association. The members of the American College of Foot and Ankle Surgeons are also members of the American Podiatric Medical Association, and we support the points made in their statement.

I am here today to ask this subcommittee to make sure that the basic benefit package in health care reform legislation includes foot and ankle services and also specifically recognizes these services when provided by doctors of podiatric medicine.

By way of precedent, I point to the Medicare statute which is comprehensive in its coverage of foot and ankle care and also includes doctors of podiatric medicine, acting within the scope of their State licensure, within the definition of "physician." This has assured the Medicare beneficiary of easy access to foot and ankle care when needed and choice of practitioner when such services are required. We ask you to include this coverage and this definition specifically in health care reform legislation.

Podiatric physicians are also recognized by Medicaid, the Department of Veterans Affairs health care system, the Department of Defense health care system, and private insurance. The American public is accustomed to having access to podiatric medical services under their current health insurance and will undoubtedly expect that such coverage will be continued in the new health care reform system.

Most people can readily agree that health insurance should cover medically necessary services for foot and ankle care. Why, then, does the college ask Congress to take the next step and assure that doctors of podiatric medicine are specifically recognized in the new health care environment?

There are really two reasons to this. The first is the historical struggle of doctors of podiatric medicine to obtain recognition and reimbursement under many insurance plans. For our members and, more important, our patients, we do not want to lose the gains of the last 50 years.

Second, and of even greater significance, is the access of patients to medically necessary foot and ankle care. Mr. Chairman, there are simply not enough M.D. providers and other specialists in foot and ankle care to meet the service needs of the American public if doctors of podiatric medicine are not included under health care reform. Using Medicare data from 1991, it is clear that doctors of podiatric medicine are providing the overwhelming majority of foot

and ankle care to Medicare beneficiaries. For example, treatment of ingrown nails and painful corns is almost exclusively done by doctors of podiatric medicine. Similarly, more complex procedures, such as the surgical repair of hammertoes, bunion deformities, and arthritic foot and ankle conditions are also largely performed by podiatric surgeons.

Mr. Chairman, this Nation is about to embark on a fundamental reorganization of the way in which health care services are financed and delivered. There is widespread agreement that this change must occur no matter how great the resistance or the difficulties. The college hopes to play a constructive role in these changes. Our members provide medically necessary and cost-effective services to millions of patients, and we believe that the public will be better served by including foot and ankle services and specifically the services of doctors of podiatric medicine in this new environment. All we ask is an equal opportunity, assured by statute, to practice and compete in this environment.

On behalf of the members of the American College of Foot and Ankle Surgeons and the patients that they serve, I want to thank you again for the opportunity to present this testimony. Thank you.

[The prepared statement follows:]

STATEMENT OF THE  
AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS  
TO THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
UNITED STATES HOUSE OF REPRESENTATIVES

ON THE  
HEALTH BENEFIT STRUCTURE UNDER HEALTH  
CARE REFORM LEGISLATION

PRESENTED BY  
LOWELL SCOTT WEIL, DPM, FACFAS

APRIL 22, 1993

Mr. Chairman and Members of the Subcommittee:

My name is Lowell Scott Weil, D.P.M., FACFAS, and I practice podiatric medicine in Des Plaines, Illinois. Currently, I am President of the American College of Foot and Ankle Surgeons (ACFAS), the surgical affiliate of the American Podiatric Medical Association (APMA). On behalf of the more than 3,400 Members of the College, I am pleased to have the opportunity to present testimony to the Subcommittee on the basic benefit structure to be contained in the health care reform legislation that we expect will be enacted during this Congress.

The American College of Foot and Ankle Surgeons (ACFAS) is a voluntary, educational, and scientific organization devoted to the ethical and competent practice of foot and ankle surgery and to the provision of high quality care for the podiatric surgical patient. To improve and advance the professional skills of its members, the College presents extensive scientific and education programs. In addition, the College promotes methods to insure high standards of surgical practice, disseminates surgical knowledge and provides information to the general public.

Mr. Chairman, at the outset let me echo the statements of Dr. Walter D. Clark, President-Elect of the American Podiatric Medical Association. The members of ACFAS are also members of APMA, and we support their call for laws protecting freedom of choice of practitioners under health care reform. Freedom of choice is valued by the American public, in health care as well as in other settings, and we strongly urge that it continue to be an operating principle in health care of the future.

I am here today on behalf of our members and the patients they serve to ask this Subcommittee to make sure that the basic benefit package in health care reform legislation includes foot and ankle services and also specifically recognizes these services when provided by Doctors of Podiatric Medicine. By way of precedent, I point to the Medicare statute which is comprehensive in its coverage of foot and ankle care and also includes Doctors of Podiatric Medicine, acting within the scope of their state licensure, within the definition of "physician". This has assured the Medicare beneficiary of easy access to foot and ankle care when needed and choice of practitioner when such services are required. We ask you to include this coverage and this definition specifically in health care reform legislation.

Since we have not yet seen the final product of the deliberations of the President's Task Force on Health Care Reform, I cannot offer specific recommendations based on that framework. However, we understand from conversations with leading members of the task force that the benefit package will be comprehensive and will cover foot and ankle services. If not, we certainly hope this committee will address that oversight promptly.



What is not clear, however, is whether specific practitioners, in addition to categories of service, will be recognized in the legislative framework to be proposed by the President. Congress has had to deal with the recognition of various health professionals over the years in both Medicare and Medicaid programs. We see no valid purpose for you to go through those political struggles again. Therefore, we recommend the use of the Medicare definition of "physician" in health care reform legislation. This is particularly important if the Administration's package is not specific on this point. To single out a class of health care providers for exclusion is unjust and without foundation.

It may be helpful to you and to the Members of the Subcommittee if I discuss podiatric medicine and its contribution to health care in this country. Doctors of Podiatric Medicine (DPM) receive four years of training at podiatric medical colleges in the United States. This training begins after completion of the Baccalaureate Degree. DPMs then proceed to various levels of postgraduate training based on their particular interest and skills. Fellows of ACFAS have received postgraduate residency training in foot and ankle surgery and have also been certified by the American Board of Foot and Ankle Surgery.

Podiatric physicians, as I have noted, are fully recognized by the Medicare program. Likewise Medicaid, the Department of Veterans Affairs health care system, the Department of Defense health care system and private insurance also recognize DPMs as licensed health care practitioners whose services are reimbursable. The American public is accustomed to having access to podiatric medical services under their current insurance networks and will undoubtedly expect that such coverage will be continued in the new health care reform system.

I earlier mentioned the importance of consumer choice and I want to emphasize how important that is for patients needing foot and ankle care. Most of our patients come directly to us when they have foot or ankle pain. Only a small percentage are referred by other primary care providers. Indeed, DPMs are seen by the public as the primary providers of foot and ankle services, from basic foot care to more complex levels of surgical reconstruction. This direct access has assured that patients can see a podiatric physician when they need to. There have been no artificial restraints, such as gatekeepers who might be predisposed to not refer to non-MD practitioners, and we encourage Congress to maintain this level of flexibility under a new health care financing and purchasing system.

In certain settings, such as major teaching hospitals including Harvard's New England Deaconess Hospital, Georgetown University Medical Center and the University of Chicago Medical Center, podiatric surgeons and other medical and surgical specialties work closely together. For example at New England Deaconess Hospital, it was realized by the divisions of podiatric medicine and vascular surgery that an aggressive multidisciplinary approach to diabetic foot ulcers could lead to a significant reduction in lower extremity amputations of all types. Individuals with diabetes commonly suffer from foot problems, including foot ulcerations and other infections. It is estimated that nearly 50% of all amputations are performed in diabetic patients for nonhealing foot ulcers. DPMs have an important role in primary care and prevention of such problems and an equally important role in treatment of the complex disorders that can occur.

It is well established through the diabetes research literature that early intervention in diabetic foot problems can prevent complications and amputations. This basic, preventive foot care is provided on a daily basis by DPMs throughout the country. Many of these services are provided in offices or other outpatient settings, thus encouraging cost effective utilization of health

care resources.

Most people can readily agree that health insurance should cover medically necessary services for foot and ankle care. Why then does the College ask Congress to take the next step and assure that DPMs are specifically recognized in the new health care environment?

There are two reasons for this. The first is the historical struggle of DPMs to obtain recognition and reimbursement under many insurance plans. For our members, and more important our patients, we do not want to lose the gains of the last 50 years.

Second, and of even greater significance, is the access of patients to medically necessary foot and ankle care. Mr. Chairman, there are not simply not enough MD providers specializing in foot and ankle care to meet the service needs of the American public. For example, using Medicare data from 1991, it is clear that DPMs are providing the overwhelming majority of foot and ankle care to Medicare beneficiaries. For example, treatment of ingrown nails and corns is almost exclusively done by DPMs. Similarly, more complex procedures such as the repair of hammertoes, bunion deformities, and arthritic foot and ankle conditions are also largely performed by podiatric surgeons. These are medically necessary services, recognized by the Medicare program and reimbursed by that program's rules.

The access issue is simply stated. If DPMs disappeared tomorrow, there would not be enough other practitioners to step in to provide these services. Failure to include the services of DPMs very specifically in health care reform could lead to large access problems for patients, both young and old, needing foot and ankle care. I have already cited to you the importance of preventive and basic foot care services for the diabetic patient in order to prevent amputation. These basic and preventive foot and ankle services are the ones provided most commonly by DPMs.

Mr. Chairman, this nation is about to embark on a fundamental reorganization of the way in which health care services are financed and delivered. There is widespread agreement that fundamental change must be undertaken and achieved, no matter how great the resistance or the difficulties. The College hopes to play a constructive role in these changes. Our members provide medically necessary and cost effective services to millions of patients, and we believe that the public will be better served by including foot and ankle services and specifically the services of DPMs in this new environment. Beyond that, we ask you for very little. We are prepared to work within the new system and to compete if that is the basis of this new mechanism. All we ask is an equal opportunity to engage in competition in this new environment. We believe that we can succeed and continue to provide the most cost effective and medically necessary foot and ankle health care to the citizens of the United States.

On behalf of the Members of the American College of Foot and Ankle Surgeons and the patients that they serve, I want to thank you again for the opportunity to present this testimony. I would be happy to respond to questions from the Members of the Subcommittee.

Mr. ANDREWS. Thank you very much, Doctor.  
Our next witness is Beth Derby.

**STATEMENT OF BETH DERBY, PRESIDENT-ELECT, FEDERATED  
AMBULATORY SURGERY ASSOCIATION**

Ms. DERBY. Good morning. My name is Beth Derby, and I am president-elect of the Federated Ambulatory Surgery Association. I thank the chairman and this subcommittee for giving me the opportunity to appear this morning.

FASA is the Nation's leading organization of ambulatory surgical centers, currently with over 400 member facilities, most of which provide surgical services in a variety of specialty areas and virtually all of which are Medicare certified.

Policymakers at all levels are absorbed these days by the question of how to deliver high-quality health care services in a patient- and provider-friendly manner and, perhaps most importantly, at a price we can afford. We in the ambulatory surgery community believe we have been doing just that. For over 20 years, surgical centers have become an increasingly central part of our Nation's health care system. In 1992, over 3 million surgical procedures were performed in surgical centers. The latest figures suggest that approximately two-thirds of all surgical cases can be performed on an outpatient basis. The use of surgical centers has saved the health care system millions of dollars relative to the cost of outpatient hospital care, let alone cost of traditional inpatient care. In fact, according to an HHS study, procedures performed in surgical centers cost the Medicare program 30 to 60 percent less than those same procedures performed on an inpatient basis.

Most of the cost advantage that surgery centers offer comes from specialization, which allows for efficient use of both personnel and facilities. More importantly, surgical centers have created competition within the outpatient surgery market. The opening of a surgical center in a particular market area has frequently been followed by a significant reduction in the charges of a local hospital for outpatient surgery, as well as increased attention on the part of the hospitals to both issues of quality of care and patient satisfaction.

If imitation is the sincerest form of flattery, perhaps the best measure of surgical centers' success is the way in which we have been emulated by the hospital industry. Over the last several years, hundreds, if not thousands, of hospitals have developed outpatient surgical facilities of their own.

Surgical centers are entirely willing and anxious to compete with hospital-sponsored programs on the basis of price and quality. In many parts of the country, hospitals have actively sought to prevent surgical centers from competing fairly. In some markets, dominant hospitals have demanded that managed care plans name them as the exclusive provider of outpatient care as a condition of providing inpatient services. Because a managed care plan cannot be without a source of inpatient services, plans presented with such a demand often have little choice. As a result, surgical centers are eliminated from the managed care arrangement, despite high quality and lower costs. In other markets, hospitals have developed their own HMO's and PPO's that categorically refuse to contract



with surgical centers, even though the surgical centers could provide outpatient surgical services for substantially less than the sponsoring hospitals.

FASA and the Nation's 1,500 surgical centers fear that these cost-increasing exclusionary arrangements could become even more common under a managed competition approach to health care reform. The plan currently being considered by the Clinton administration needs to keep competition in the system. We believe that any health care reform plan must not only include surgical centers in the minimum benefits package, but additionally include specific measures to prevent hospitals from using their market power to force surgical centers out of business and, over the long run, increase rather than decrease the cost of health care.

We ask that in formulating health care reform legislation this subcommittee and Congress consider five specific proposals with regard to surgical centers.

First, we urge Congress to specifically include the services of surgical centers in the minimum benefits package.

Second, in order to ensure that there are adequate opportunities for surgical centers to compete, we propose that Congress require that there be several health insurance plans in each area that are not sponsored by hospitals or hospital affiliates and at least one plan that allows for an open panel that would permit the participation of all qualified health care facilities.

Third, we ask that Congress include provisions that would prevent hospitals with dominant market power from tying the provision of inpatient services to the provision of outpatient services.

Fourth, because we recognize that Federal oversight of provider contracting is not practical, we propose that the oversight responsibility be delegated to the health insurance purchasing cooperatives. The HIPC's should require that hospital-sponsored insurance plans demonstrate that they have given fair opportunities to nonhospital facilities to participate in their provider networks.

Fifth, we request that Congress instruct the HIPC's to scrutinize the provider contracts of authorized health plans, to ensure that plans are not inappropriately excluding freestanding facilities and that providers are not engaging in pricing strategies that will, over the long run, impair competition.

I must emphasize that we feel strongly that these requirements need to be spelled out clearly in Federal legislation, rather than being left to individual States.

Mr. Chairman and members of the subcommittee, on behalf of the Federated Ambulatory Surgery Association, I thank you for the opportunity to appear before you today. I look forward to working with you to improve the accessibility to and reduce the cost of our country's health care system.

Mr. ANDREWS. Thank you very much.

Our last witness on this panel is Herbert Gorlin. Mr. Gorlin.

Mr. GORLIN. I believe there is one before me, sir.

Mr. ANDREWS. Oh, I am sorry, Dr. O'Toole. I didn't mean to skip you. Please go ahead. Introduce yourself to the committee, and please proceed.

## **STATEMENT OF THOMAS J. O'TOOLE, ED.D., PRESIDENT, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION**

Mr. O'TOOLE. Thank you, sir. Good morning. I am Thomas J. O'Toole, president of the American Speech-Language-Hearing Association (ASHA), the professional, scientific, and accrediting organization for more than 74,000 speech-language pathologists and audiologists. We work in a variety of settings: in neonatal intensive care units, schools, hospitals, rehabilitation centers, nursing homes, as well as in private practice.

ASHA applauds the chairman's longstanding effort in health care reform and the understanding shown for individuals with disabilities. Our professionals treat from the very youngest to the very oldest of our populations. We help children with cleft palates, and we helped aging loved ones with Alzheimer's disease. The ability to communicate is vital for a healthy, productive, and independent life. This ability can be impaired by disease, illness, and injury, such as stroke, traumatic brain injury, substance abuse, and tinnitus.

Aphasia and hearing loss are two examples that demonstrate the importance of services provided by speech-language pathologists and audiologists. Take the heart-warming case of George Suarez, mayor of Madison Heights, Mich. The Daily Tribune reported, "Mayor George Suarez is back chairing city council meetings after more than 4 months of therapy for a stroke." Mayor Suarez, 66 years old, suffered a stroke that caused a speech and language disorder called aphasia. After 4 months of inpatient speech-language pathology treatment and 2 more months of outpatient treatment, he not only returned to his mayoral duties, but resumed his job as Oakland County Road Commission Director of Central Operations. Mayor Suarez said, "It's speech and language therapy. You know the language, and it's buried inside. When you have a stroke, and that portion of the brain dies away, you have to go back and put that learning in another part of your brain."

A shocking example of the consequence of lack of audiology services is the case of a child institutionalized as mentally retarded for 10 years before it was confirmed that he was of normal intelligence but deaf. Early intervention with audiology services for children would have prevented the lamentable misdiagnosis and inappropriate placement.

Early identification of communication disorders coupled with speech-language or audiology intervention results in improved communication. It reduces the need for special education programs. The role of the audiologist in delivering services to people with hearing loss cannot be overemphasized. These services are both efficacious and cost-effective. Audiologists assess and provide rehabilitation to people with hearing loss by working directly with the primary care physician.

Speech-language pathology and audiology services are provided in the Medicare and Medicaid programs, the Department of Veterans Affairs medical centers, and private health plans. This includes coverage for the diagnosis and rehabilitation services for those with speech-language, hearing, swallowing, cognitive, and balance disorders.

ASHA recommends that the subcommittee study the audiological and speech-language pathology program at veterans medical centers because that program can be used as a model for creating benefits for adult Americans with speech-language, hearing and related disorders.

In closing, any impairment in our ability to speak or hear dramatically changes our lives. It affects the way we learn about the world around us, how we use our knowledge and skills, and how we interact with our families, friends, and colleagues.

ASHA believes that Congress must ensure that audiology and speech-language pathology services be included in reform of that system. Preventing, assessing, and treating speech-language and hearing disorders is vital to all Americans.

Thank you.

[The prepared statement follows:]



**Ways and Means Testimony**  
**April 22, 1993**  
**Thomas J. O'Toole, Ed.D.**

If my possessions were taken from me with one exception I would choose to keep  
the power of communication for by it I would soon regain all the rest.

Daniel Webster

Good morning, Mr. Chairman. I am Thomas O'Toole, President of the American Speech-Language-Hearing Association (ASHA), the professional, scientific, and accrediting organization for more than 74,000 speech-language pathologists and audiologists. My purpose today is to describe the health care needs of children and adults with speech, language, hearing, and related disorders. ASHA applauds the Chairman's efforts in health care reform and the understanding shown for individuals with disabilities. I will focus on the special needs of people who have lost or never had the ability to communicate. I want to provide you with the rationale for including the services of speech-language pathologists and audiologists in the basic benefits of a health reform proposal.

I want to emphasize at the outset that ASHA enthusiastically endorses the health reform positions of the Consortium for Citizens with Disabilities (CCD) and the National Rehabilitation Caucus (NRC). The principles set forth by CCD are accurate in describing the needs of individuals with disabilities. I am including a copy of the ASHA Position Statement on National Health Reform with the hope that the Committee will see how ASHA's principles are consonant with those of CCD. Additionally, we support the NRC position statement because of its focus on the efficacy of services rendered by rehabilitation professionals, such as audiologists, occupational therapists, physical therapists, and speech-language pathologists.

Today, I urge that the Committee focus its attention on the special health needs of individuals with communication and related disorders. Too frequently, health care policymakers confine their thinking to physical illnesses and mortality considerations, physical disabilities apparent at birth, or physical problems that result from accidents. However, the ability to communicate is essential for a healthy and productive life. This ability can be impaired by disease, illness, and injury such as stroke, head injury, cleft palate, cerebral palsy, and hearing loss. Morbidity considerations must be addressed in health care reform to ensure independent living.

### Consumer's Perspective

Many conditions result in speech, language, hearing, or related disorders but aphasia and hearing loss are two examples that will be used to illustrate the position of ASHA. During the recent expert panel discussions on post-stroke rehabilitation at the Agency for Health Care Policy and Research, a number of consumers wrote to describe their experiences with aphasia, a language disorder that frequently is a consequence of stroke. Roger Ross, a printing and publishing consultant and former mayor from New Jersey, wrote about his experiences following a stroke that occurred on January 10, 1991. Within six months he described himself as "physically fine," but his "big problem" was the "inability to speak and write." At the time of his testimony, June 7, 1992, he wrote, "I do not know how I could have survived this period without the concern of all the speech therapists (-language pathologists), who helped me not only to speak but to think positively about the future."

Craig Robertson, a 37-year-old who had a stroke that caused right-sided paralysis and severe aphasia spoke at the same meeting. He testified on how his aphasia continued to improve one year post-stroke. He asked that policies not limit or ration speech-language treatment to weeks or months, but instead consider the potential for improving the quality of life.

ASHA learned about another consumer's experience from the public press. One of our members from Michigan recently sent ASHA a news story about the mayor of Madison Heights. "Mayor George Suarez is back chairing city council meetings after more than four months of therapy for a stroke" reads the first sentence in the March 24, 1993, *Daily Tribune* feature. Mayor Suarez, 66-years-old, had a stroke in December that caused a speech and language disorder. After four months of speech-language pathology treatment at William Beaumont Hospital, and two more months of outpatient treatment, he not only returned to his mayoral duties but resumed his job as Oakland County Road Commission Director of Central Operations. Mayor Suarez said, "It's speech and language therapy. You know the language, and it's buried inside. When you have a stroke, and that portion of the brain dies away, you have to go back and put that learning in another part of your brain."

The need of a consumer of audiology services best concludes this section and provides an ideal transition to efficacy of services. In 1983, there was a report of a child who was institutionalized as mentally retarded for 10 years before it was confirmed that he was of normal intelligence but deaf (*Snow v. State of New York*, 1983, 469 *New York Supplement*, 2nd Series). The efficacy of early intervention with audiology services would have prevented the serious misdiagnosis and consequent placement of the child.

Audiology and speech-language pathology services benefit the health of Americans and must be retained in health care reform.

### Efficacy

There is clear evidence that early identification of communication disorders coupled with speech, language, or audiology intervention results in improved communication and thus reduces the need for special education programs (Snyder-McLean, and McLean, 1987).

At the other end of the aging spectrum, speech-language pathologists often work with individuals who have language disorders caused by stroke (i.e., aphasia). Shewan (1986) summarized the research by stating

In summary, more than a dozen studies attempting to address the efficacy issue have reported language treatment as beneficial...their consistently positive data support a conclusion that language therapy is efficacious. Darley (1982), who posed the questions (of efficacy), concluded with this statement 'The foregoing collage of studies . . . collectively provides a series of answers and together lays our doubts about efficacy to rest.'

More than 22 studies spanning from 1946 to 1984, and more since that time, continue to objectively demonstrate efficacy of treatment by speech-language pathologists.

Logemann (1992) described the efficacy of speech-language pathologists' treatment in combating swallowing disorders. She wrote about a treatment technique that alone has been found to be 75-80% effective in eliminating aspiration (entry of food into the airway below the vocal folds) in stroke patients.

The role of the audiologists in efficacy and cost-effectiveness in service delivery to persons with hearing loss cannot be emphasized enough. Audiologists reduce the cost of hearing services because they can assess and provide rehabilitation to individuals with hearing loss by working directly with the primary care physician. Costly assessment by medical specialists is avoided when the diagnostic and rehabilitative treatment is provided by the audiologist and results are communicated directly to the primary care physician.

### Demographics

The number of Americans with various communication disorders is important in the consideration of coverage because the demographics illustrate the need for services.

The prevalence of hearing impairment has been estimated in the United States to be 8% of the civilian non-institutionalized population or 17.4 million Americans, 1% of whom are deaf (Punch, 1983). For those over age 65, the prevalence rate is 29.75%. As a direct result of aging, demographers have estimated that hearing impairment will increase approximately 102% in the population as the total U.S. population increases 36% (Cherow, 1986).

In a 1981 report to the White House Conference on Aging, Miniconference on Elderly Hearing Impaired People, Stone wrote:

Much has been written about the tendency of older people to withdraw from familiar life patterns and eventually to become isolated. There are many roads to isolation, but one of the shortest (and fastest) is loss of hearing.

The situation is getting worse. As we move from an industrialized society, the key resource becomes what is in our heads. But what is in our heads today, and will be tomorrow, gets there largely in the sounds mode.

Demography is important in understanding hearing loss in underserved populations. It is estimated that 3.5 million, or 10% of the native minority population, have communication disorders unrelated to the use of foreign language (Cherow, 1986). In prison populations, 35–45% of all youthful offenders suffer impaired hearing due to middle ear pathology. Seventy percent of juveniles could not meet normal levels for speech and language.

Nearly 1.8 million adults in the U.S. have aphasia. An unknown number of young adults and teenagers are also experiencing similar aphasia-like speech and language problems caused by drug abuse.

Another 24,000 Americans have undergone surgery for removal of the larynx (voice box) due to cancer and must learn new methods of speaking.

Over 2 million people age 18 to 64 have hearing and/or speech impairments that render them unable to work.

### Current Health Care Programs

Speech-language pathology and audiology services are provided for individuals with speech, language, and hearing disorders in the Medicare and Medicaid programs, Department of Veterans Affairs Medical Centers, and private health plans. The diagnostic and rehabilitation needs of individuals with speech, language, hearing, swallowing, cognitive, and balance disorders are being met by speech-language pathologists and audiologists within the scope of coverage of these programs.

Medicaid includes services for individuals with speech, language, and hearing disorders as options for adults. The optional nature of the benefit has created severe inequities for adults among the states. While more than half of the states cover speech-language pathology and audiology services, the others cover only inpatient hospital services. Even worse, some states target services for individuals with speech, language, and hearing disorders for elimination during fiscal crises but usually retain them when the agency or legislators learn of the positive outcomes and the low costs. For children, the early and periodic screening, diagnosis, and treatment program (EPSDT) mandates the inclusion of services for communication disorders. The EPSDT program can serve as a model of prevention services for all infants and children. Early identification and early intervention avoids the need for lengthy and expensive service later.

ASHA is involved in a coalition with other national organizations that advocate for universal hearing screening so that intervention services can be provided and the child's critical formative years can be used for developing language and cognition so necessary for academic achievement and social-emotional growth. These programs should be incorporated in a health reform package.



Medicare coverage guidelines for speech-language pathology claims were published in 1981. They remain as a useful model for all claims. The concept of reasonable and necessary services in Medicare for speech-language pathology services is determined by four factors: services must be delivered under accepted standards of practice; services must be skilled, sophisticated, and complex; significant practical improvement must be expected; and the amount, frequency, and duration of services must be reasonable under accepted standards of practice.

Unfortunately, at present, coverage of audiology for those with hearing loss under Medicare is severely limited. Unlike coverage under Medicaid, Medicare does not cover hearing tests if there is a complaint of hearing loss. Only when the diagnostic audiologic service is helpful in the diagnosis of a hearing or balance disorder to assist in medical treatment does Medicare coverage apply. ASHA believes that health care reform must rectify this requirement in health care reform with the knowledge of the benefits of hearing rehabilitation.

The Veterans Affairs Department Medical Centers (VAMCs) have had successful audiology and speech-language pathology programs since World War II. Their programs are complete with diagnostic and rehabilitation services in both audiology and speech-language pathology. If assistive technology can benefit those with speech and hearing disorders, it is provided. ASHA recommends that the Subcommittee investigate the audiology and speech-language pathology program at the VAMCs and use it as a model for creating benefits for individuals with speech, language, hearing, and related disorders.

Private health plan coverage is extensive according to an ASHA survey of the service and manufacturing Fortune 500 companies. ASHA found that most of the 174 companies that responded cover speech-language pathology services. Most companies (82%) indicated coverage of services if the speech-language disorder was due to an accident or illness. An identical percentage covered audiologic assessment, whereas only 22% covered hearing aid assessment, fitting, and orientation. Only 23% included aural rehabilitation coverage. These findings support the inclusion of audiology and speech-language pathology services in health reform benefit design.

In 1986, the Health Insurance Association of America (HIAA) distributed a Report on Consumer and Professional Relations regarding Speech-Language Pathology and Audiology. HIAA wrote that "(T)here is no requirement for medical prescription or supervision since the profession(s) is autonomous." The HIAA Allied Health Services Committee concluded: "Speech-language pathology and audiology services are important rehabilitation and habilitation programs." ASHA concurs with this statement.

ASHA stresses the importance of defining an audiology rather than a hearing benefit. A hearing plan can mean anything from hearing screening to a full hearing system benefit. Because of the comparison to vision care plans, ASHA expects that the hearing benefits reported by benefits organizations refer to hearing aid system benefits rather than diagnostic and rehabilitative audiology services that are most likely covered.

### **Definitions and Descriptions of Audiology and Speech-Language Pathology Services**

#### **Audiology**

Audiologists are health care professionals who specialize in prevention, identification and assessment of hearing disorders and provide treatment, and rehabilitation services. Audiologists

- test and diagnose hearing and balance disorders in infants and children as well as adults;
- help prevent hearing loss through hearing conservation programs in industry, schools, and wellness programs;

- treat adults and children needing aural rehabilitation services such as auditory training, speech reading, and sign language instruction;
- conduct research into environmental influences on hearing, new testing methods, and innovative rehabilitation devices such as cochlear implants; and
- prescribe and dispense hearing aid systems and assistive listening devices and instruct people in their use.

The practice of audiology includes

- facilitating the conservation of auditory system function;
- developing and implementing environmental and occupational hearing conservation programs;
- screening, identifying, assessing, interpreting, diagnosing, preventing, and rehabilitating peripheral and central auditory system dysfunctions;
- providing and interpreting behavioral and electro-physiological measurements of auditory and vestibular functions;
- selecting, fitting and dispensing of amplification, assistive listening and alerting devices and other systems (e.g., implantable devices) and providing training in their use; and
- providing aural rehabilitation and related counseling services to hearing impaired individuals and their families.

The term "audiology services" refers to hearing and balance assessment and rehabilitation services furnished by a qualified audiologist, including assessments to determine the need for medical or surgical treatment of hearing loss, or for hearing aids, or assistive listening, or alerting devices, and such services and supplies furnished incident to such services as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law).

The term "qualified audiologist" means an individual with a master's or doctoral degree in audiology who has performed not less than 9 months of supervised fulltime audiology practice after obtaining such degree and who

- is licensed (or is otherwise certified) as an audiologist by the State in which the individual furnishes such services (currently 42 states regulate the practice of audiology), or
- in a State that does not provide for the licensing (or other form of certification) of audiologists, has successfully completed a national clinical competency examination in audiology approved by the Secretary of Health and Human Services.

### **Speech-Language Pathology**

Speech-language pathologists treat speech, language, voice, and swallowing disorders. Among the range of services provided, speech-language pathologists

- provide rehabilitation services for stroke patients to help them regain their use of language;
- treat people who are nonspeaking and use augmentative and assistive communication devices ranging from simple to complex systems; and
- treat children who have language delays and impaired speech.

The scope of practice for speech-language pathologists includes

- screening, identifying, assessing, interpreting, diagnosing, rehabilitating, and preventing disorders of speech (e.g., articulation, fluency, voice), and language;
- screening, identifying, assessing, interpreting, diagnosing, rehabilitating, and preventing disorders of oral-pharyngeal function (e.g., swallowing) and related disorders;
- screening, identifying, assessing, interpreting, diagnosing, and rehabilitating cognitive/communication disorders;
- assessing, selecting, and developing augmentative and alternative communication systems and providing training in their use; and
- providing aural rehabilitation and related counseling services to hearing impaired individuals and their families.

The term "speech-language pathology services" refers to speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist, and supplies furnished incident to such services (including augmentative and alternative communication devices), as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law).

The term "qualified speech-language pathologist" means an individual with a master's or doctoral degree in speech-language pathology who has performed not less than 9 months of supervised fulltime speech-language pathology services after obtaining such degree and who

- is licensed (or is otherwise certified) as a speech-language pathologist by the State in which the individual furnishes such services (currently 42 states regulate the practice of speech-language pathology), or
- in a State which does not provide for the licensing (or other form of certification) of speech-language pathologists, has successfully completed a national clinical competency examination in speech-language pathology approved by the Secretary of Health and Human Services.

Speech-language pathologists are experts in swallowing assessment and treatment. The speech-language pathologist is the recognized professional to work in this area because of the anatomical and physiologic similarity between speaking and swallowing. Many different medical conditions can cause swallowing difficulties. Individuals with stroke, head injury, or spinal cord injury may have difficulty swallowing as do patients who have diseases that affect their muscle strength or coordination. Patients with muscular dystrophy cerebral palsy, or even diabetes may have difficulty swallowing. Progressive neurological diseases such as Parkinson's disease, amyotrophic lateral sclerosis, myasthenia gravis, and multiple sclerosis may also cause swallowing problems. The speech-language pathologist can assess and treat the individual and, in many instances, bring the patient to a level where tube feeding is no longer necessary and hospital care is no longer required. Often, intensive care in a nursing facility is no longer necessary because the speech-language pathologist helps the individual become more independent.

Speech-language pathologists also treat patients with voice disorders. In some cases, voice treatment negates the need for vocal cord surgery. Although ASHA has records of health plans disallowing the service, the health insurance plan reverses its decision when given the data on voice recovery and the avoidance of costly surgery.



### Summary and Recommendations

ASHA has defined, using rigorous scientific discipline, the scope of practice of the speech-language pathology and audiology professions, developed position statements regarding the assessment and treatment of individuals with communication or related disorders, described the procedures and diagnoses made by the professions, and, most recently, published preferred practice patterns for the professions. ASHA's goal, and that of the members ASHA represents, is to provide quality services to individuals with communication disorders.

Any impairment of our ability to communicate can have far-reaching consequences because it affects the way we learn about the world around us, use our knowledge and skills, and interact with our colleagues, family, and friends.

The ability to communicate is essential for healthy, productive, and independent living. Comprehensive health care includes the diagnostic and treatment services of qualified audiologists and speech-language pathologists. Audiologists and speech-language pathologists are important contributors to the American health care system.

ASHA believes that Congress must ensure that audiology and speech-language pathology services be defined in health care reform legislative language. These prevention, assessment, and treatment services are vital to Americans.

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## APPENDIX

# Position Statement on National Health Policy

*Ad Hoc Committee on National Health Policy  
American Speech-Language-Hearing Association*

*This position statement is an official policy of the American Speech-Language-Hearing Association (ASHA). It was developed by the ASHA Ad Hoc Committee on National Health Policy. Members of the ad hoc committee include Lisa K. Breakey (chair), Maria Langerais Baca, Linda H. Gillum, Thomas S. Rees, Sharyn A. Tukey, and Steven C. White (ex officio). Vice President for Governmental and Social Policies Jean H. Lovrinic provided guidance and served as monitoring vice president. Roger P. Kingsley, Connie Lynch, and Sydney Olson assisted in the preparation of the statement.*

It is the position of the American Speech-Language-Hearing Association (ASHA) that national health policy must recognize audiology and speech-language pathology services as basic, necessary, and essential to an individual's health and welfare, and that such policy must adhere to the following 12 principles.

1. Provide universal access to consumers.

National health policy must include uniform eligibility and permit participation regardless of pre-existing condition(s), prognosis, income level, risk factors, or employment status. The policy must not discriminate on the basis of race, national origin, religion, age, gender, sexual orientation, or disability.

2. Recognize individual needs.

National health policy must give priority to the health needs of the individual consumer when type, frequency, initiation, and duration of services are being determined. Provision must be made for the full participation of the consumer or the consumer's representative in the determination of healthcare needs.

3. Ensure quality of life.

National health policy must be based on the proposition that improvement or maintenance of communication enhances an individual's ability to live independently and participate as fully as possible in the community. Quality of life is as important as length of life.

4. Ensure consumer and professional representation for policy development and implementation.

National health policy must reflect the interests of consumers and providers, including audiologists and speech-language pathologists, and ensure their involvement during the development, implementation, and refinement of healthcare programs.

5. Support consumer education.

National health policy must include programs of education that focus on the prevention of communication dis-

orders and inform consumers of the vast array of healthcare services and the processes necessary to obtain the services.

6. Allow consumers to choose provider settings.

National health policy must allow consumer choice of audiology and speech-language pathology services, service providers, and service sites.

7. Cover comprehensive services.

National health policy must include comprehensive audiology and speech-language pathology services. The professional determination of appropriate preventive, diagnostic, habilitative, and rehabilitative services, as defined by preferred practice patterns of the professions, will be made by audiologists or speech-language pathologists.

8. Provide cost-effective services.

National health policy must reduce administrative complexity, minimize administrative costs, and balance resources among preventive services, acute care, habilitation, rehabilitation, and chronic care management to ensure the delivery of cost-effective audiology and speech-language pathology services.

9. Ensure broad-based financing.

National health policy must incorporate the most effective combination of public and private funds to ensure comprehensive individual coverage.

10. Support research.

National health policy must support research programs in prevention, diagnosis, habilitation, and rehabilitation of communication disorders.

11. Recognize the autonomy of the audiology and speech-language pathology professions.

National health policy must recognize the autonomy of audiologists and speech-language pathologists who possess the ASHA Certificate of Clinical Competence and state licensure where required.

12. Provide access to necessary assistive and augmentative technology.

National health policy must ensure consumer access to necessary assistive and augmentative technology that improves or maintains functional communication with concomitant training and services.

*Reference this material as follows:*

American Speech-Language-Hearing Association. (1993). Position statement on national health policy. *Asha*, 35, (Suppl. 10), pp. 1.

Mr. ANDREWS. Thank you.

Now, our last witness is Herbert Gorlin. Mr. Gorlin.

**STATEMENT OF HERBERT D. GORLIN, PRESIDENT,  
INTERNATIONAL HEARING SOCIETY**

Mr. GORLIN. Thank you, Chairman. My name is Herb Gorlin. As president of the International Hearing Society, I welcome the opportunity to appear before you today to advocate the necessity of including periodic basic hearing screenings in any standard benefits package you consider. IHS is the professional association of hearing aid specialists whose membership of over 4,000 represents the most experienced and competent providers of hearing testing services, hearing aid selection, fitting, dispensing, repair services, and ongoing followup care on an everyday basis.

I have been a hearing aid specialist for 32 years and, together with my wife and 2 children, who have earned their degrees in audiology, operate a small hearing aid business in south Florida. I have been a member of the Medicaid Advisory Council for the State of Florida charged with allocating the funds available for the Title 19 program and also first chairman of the Hearing Services Peer Review Committee for the Florida Medicaid program. We are part of an industry that is tremendously underutilized. Some 20 to 26 million Americans are afflicted by some degree of hearing impairment, yet only a fraction of these individuals receive some treatment for their hearing loss. Indeed, only 5 million Americans today wear hearing aids, the recommended intervention for the vast majority of hard-of-hearing persons.

The basic hearing screening which IHS supports including in a standard benefits package could be provided by a number of provider groups, including primary care physicians, hearing aid specialists, and audiologists. Indeed, the hearing screening could be a required component of routine physical examinations as part of the benefit package.

We are not presently advocating inclusion in the benefits package of followup diagnostic services or hearing aids because we recognize that the cost of including these items at this juncture would be prohibitively expensive. We are hopeful, however, that as health reform is implemented and costs contained, consideration will be given to expanding the benefits package to include the followup care to hearing screening.

In the interim, we are convinced that early detection of hearing loss would be an invaluable benefit to all Americans. This detection would readily identify the 5 percent of the hearing-impaired who are candidates for medical and surgical treatment. Most of the remaining 95 percent who are candidates for hearing aids do not currently utilize amplification. This dramatic underutilization is typically attributable to a lack of awareness of hearing loss or denial of hearing loss due in large part to the gradual nature of its onset. In addition, some uninformed people still attach a social stigma to the wearing of hearing aids. These psychological barriers could be overcome by including basic hearing screening exams as part of primary medical care. With periodic screenings, Americans would become acclimated to gradual hearing loss and the notion that one day hearing aids may be the appropriate intervention.



It is true that, in most instances, early detection of hearing loss will not translate into millions of dollars saved in chemotherapy treatment by virtue of early detection of a tumor. What we are speaking to is identification of the loss of one of the five senses that, if untreated, will dramatically impair the functioning of one's life. While fitting individuals for a hearing aid will not save their lives per se, it would save the quality of their life, possibly save them from being hit by a vehicle they cannot hear, possibly save a job from which they might be fired, or possibly save them from inappropriate confinement in a nursing home due to misdiagnosis. Society will save money if the millions of Americans who are hearing aid candidates are identified early on. We just cannot readily quantify these savings.

The type of hearing screening that we are advocating is extremely basic. The exam lasts 3 to 5 minutes. It would not entail sizable costs because the equipment utilized is not expensive. Charges for such screening typically range from gratis to \$15. Further, if hearing loss screening services are encompassed in routine physical examinations, the benefit would not be separately costed out. Regardless of how the Federal Government chooses to provide for the benefit, it is important to recognize in the law that State-licensed hearing aid specialists, audiologists, and primary care physicians are equally qualified to provide the basic screening service. As such, legislation or regulation providing for the hearing screening service should not be provider specific.

It is exciting that America is recognizing the importance of preventive care services as the cornerstone to our Nation's health. Detection of hearing loss should be considered among the preventive care services that are fundamental to ensuring total health.

Thank you for this opportunity. I would be pleased to answer any questions you may have.

Mr. ANDREWS. Thank you very much.

Dr. Clark, please tell the committee why you think it is so important that Congress makes the decision of who and what goes into a basic plan.

Dr. CLARK. What I really feel is that the Congress of the United States is like any big business. You control your money, and the taxpayers give it to you. And I think it is incumbent upon anybody that runs a large business to make sure their dollars are spent extremely well.

I think the responsibility lies with the Congress because they are given that money and, therefore, they are going to be the expenders of it. And they should make sure that the citizens of this country get the benefits that those dollars are buying.

I also think that a small limited group of people will not have the ability to understand the impetus from all the individuals throughout this country. The Congress of the United States listens to the rank and file people of this country, and I think they will listen to what the benefits are that the individuals want and will supply it within a mandated package that will be beneficial to the citizens of this country more than any single eight-member board.

Mr. ANDREWS. Well, first, what would you do if you were left out of the package?

Dr. CLARK. Me personally, if I was left out? I would simply continue to provide the finest quality care that I could provide as I have been providing for 17 years, and I will probably continue to be able to practice in my general locale. It would not be as nice, maybe, as it would be under other circumstances. It would put a tremendous hindrance on the citizens that comes to see me being left out of something that they should be entitled to.

Mr. ANDREWS. I guess I pose that question because I really respectfully don't agree with your premise. I am a big advocate of managed competition myself and certainly feel that that is the way to go. I am curious what all of you think about this particular issue. It just seems to me weighing a blue-ribbon kind of panel that would make those decisions—chosen by the Congress, of course, but a group of experts making the kind of decisions, health care decisions, as opposed to Members of Congress making those decisions is a better approach and a more responsible way to go.

I don't know that much about each of your practices and how it impacts on the overall health and safety of the American people, in fact, or where it really fits into basic health care decisions. I want to learn.

As a member of the Health Subcommittee, I probably have the opportunity to know a lot more than some of my colleagues from other parts of the country, and I worry that if we leave these decisions only up to the Congress, it will be, first, hard to say no to anyone. There is a chiropractic college in my district. They are anxious to be included in the plan and make, frankly, a very compelling argument as to why they should be. I don't know whether they should be or not.

But I can see a situation where your Congressman, Dr. Clark, would feel compelled to fight for you as his constituent, and those feelings may override health care decisions, economic decisions, cost-effective decisions that I think are probably pretty important as we try to move toward this goal of managed competition and a more lean, cost-efficient system.

So I say this really to invite your disagreement with me, if nothing else. Don't worry about disagreeing with me, Dr. Clark, but I really am concerned that, if left to Members of Congress, we may have decisions that are based more on politics and regional interests and who is the best lobbyist as opposed to decisions that are primarily focused on cost efficiency and basic health care and what should go into a particular package.

Would anyone care to comment? Dr. Elliott.

Dr. ELLIOTT. Well, I think that the issue that you are bringing to the table is an important one, and all of us are very concerned about fairness. Certainly, historically, those of us who are practicing optometry and podiatry and so forth, that are not included in the M.D. category, are very concerned about a panel that is physician dominated and just what kind of—

Mr. ANDREWS. Who suggests it would be physician dominated?

Dr. ELLIOTT. Well, if the numbers are very small, that is historically what has happened. Certainly at State levels and certainly at the national level, that has been true. And hearing Mrs. Johnson before, physician dominated but not physicians who practice, which is another concern.



So we are concerned with the politics of fairness as it would come down.

Mr. ANDREWS. You don't think that by leaving it up to Congress you make for more politics in this health care?

Dr. ELLIOTT. Well, I think that Congress has to be involved far enough down to keep the devil out of the details, and I think that that certainly can be done. I think that the patients that we serve, it is important to protect their interests. If that is not going to happen within a panel structure, we are very concerned.

Mr. ANDREWS. What if it doesn't happen within a congressional structure?

Dr. ELLIOTT. I think it is much more likely to, for the reasons that you stated before, that we have advocacy——

Mr. ANDREWS. Because of the politics?

Dr. ELLIOTT. Because we have advocacy. We have a chance to have a voice.

Mr. ANDREWS. Yes. See, that concerns me. I think that is a very wrong reason why you should be included or not included in a basic plan.

If a panel were devised that you thought was fair——

Dr. ELLIOTT. Now, that is another story. You know, how do you propose to do that?

Dr. VARLEY. I just wanted to respond to your question and observation. Certainly if Congress is involved, decisions that are made will be political, and that is a given. But Congress is the only group with whom the provider and those who are being provided for can have some say. We can go to a poll and we can vote. An independent panel—depending on how it gets constituted—may basically be beyond our control.

Mr. ANDREWS. What did you say about the way it is constituted? Because that is very important.

Dr. VARLEY. I don't know how it would be constituted.

Mr. ANDREWS. If it is constituted by the Congress in a way that is fair——

Dr. VARLEY. Beg your pardon?

Mr. ANDREWS. If it is constituted by the Congress in a way that is fair, if you, Dr. Varley, have every opportunity to petition based on the merits of why you should be included in a basic plan, does that trouble you?

Dr. VARLEY. I still think there are issues that are involved, not just for the provider——

Mr. ANDREWS. What would they possibly be?

Dr. VARLEY. There could be issues that would affect the consumer, which is who we really basically need to be concerned about, not we providers, but basically the consumer. The consumer at least goes to the polls and elects all of you here in Congress. He or she participates in that process or has an opportunity to do so. The consumer has no way of having a voice in an independent panel who might be making decisions about their health insurance, their health care, and they have absolutely no way, or only in a very indirect way, to influence those decisions.

This is just my position. You know, I am obviously open for discussion.



Dr. WEIL. I think it all depends on how the national panel is derived and how it is constituted. Certainly we feel that if we have appropriate input, as we would with Congress—we know the type of input we have with Congress. This is historical and a way we can manage. When it is an unknown entity out there, such as a national panel, we see the worst all the time. We see it as adversaries. We see it as competitors who will lock us out of the competition, which will not only hurt us but hurt our patients from being able to gain the adequate care that they deserve.

So I think that we are open, depending on how this panel is formulated, how it is constituted, but right now we feel comfortable with the fact that Congress would give us the appropriate recognition, the appropriate hearing, hearing the issues and the needs that we and our patients have.

Mr. ANDREWS. Ms. Derby.

Ms. DERBY. I believe that one of the concerns we would have as a provider of care is continuing to be a player on the field. And if the panel were constructed in a way that was fair and open and equal, willing to hear providers present information that would help them make an unbiased decision, I think we would certainly endorse it. Our concern would be that there would be people who would have more clout or have a broader spectrum of power to wield, and that would skew the field in terms of providers such as ourselves.

Mr. ANDREWS. Dr. O'Toole.

Mr. O'TOOLE. Let me just add to that, the tone of the other members in the panel. I would agree that Congress would be, at this point in time, the best place to house this oversight. And I certainly would be open, as others have stated, to looking at the proposal of a panel and the constitution of a panel. But Congress is beholden to the taxpayer, and the taxpayer will be putting an awful lot into this effort.

Mr. ANDREWS. Thank you all very much.

All the same rules would apply. I will ask you to try to give us a narrative of your testimony. Your full testimony will be made a part of the record. Please try to keep an eye the lights. When it turns red, please try to end your remarks.

I appreciate all of you for being here. Why don't we, just for the sake of brevity, start to my left with Mr. Palermo, and I will ask just to go across the witness table. And I would like for each of you to introduce yourselves and give us a description of who you represent. Then please proceed with your testimony.

Mr. Palermo.

#### **STATEMENT OF STEVE PALERMO, SPOKESPERSON, MEDICAL REHABILITATION EDUCATION FOUNDATION, AND UMPIRE, AMERICAN BASEBALL LEAGUE**

Mr. PALERMO. Thank you, Mr. Chairman. My name is Steve Palermo. I am a major league umpire working in the American League, and I am here representing the Medical Rehabilitation Education Foundation. What I am here to do is to increase public awareness and understanding of the value of medical rehabilitation.

This subcommittee faces an awesome task: to help restructure and/or to reinvent the entire health care system to ensure that it is available to all Americans. I am honored to be part of this effort and hope that my experience will in some small way help others.

About 2 years ago, friends and I tried to help two women who were being attacked in a parking lot. To make a long story short, I was shot in the back by the attackers. The bullet cut my spinal cord, and my legs were paralyzed. The doctors told me I would never walk again. You have witnessed, if you noticed, that I walked here to this table today to address you.

I have spent the last 2 years undergoing intensive medical rehabilitation, and you can see the results. The Medical Rehabilitation Education Foundation will submit a detailed report, with facts and statistics, for the hearing record. I will address some key points.

As a result of medical rehabilitation, an estimated 350,000 Americans return to work each year. This results in savings of \$1 to \$2 billion per year for public programs such as workers' compensation, disability insurance, and Medicaid. In time, I will be back on the baseball field, paying Federal and State income taxes instead of running up medical bills. And I will not be receiving Social Security disability insurance benefits, as I am currently doing, from the U.S. Government.

Medical rehabilitation is cost-effective, saving hundreds of millions of dollars a year in medical bills.

From my firsthand experience, medical rehabilitation is not an option, it is a necessity.

Access to inpatient and outpatient rehabilitation care and community-based medical rehabilitation services must be part of the basic health care reform package offered all Americans in any legislation enacted by Congress.

One final point. Time is both an ally and an enemy to medical rehabilitation. I have been lucky enough to receive all the rehabilitation necessary in the past 2 years. Time has been my ally.

But I have met other patients, including children, where time was the enemy. Their progress was interrupted because their benefits ran out. They had to wait, lose momentum, and quite often regress, because their insurance wouldn't cover additional weeks of rehabilitation. Some patients reach the lifetime cap for their condition and are doomed to spend the rest of their lives never reaching their full potential for rehabilitation.

We become outraged when we see news on television of inhumane treatment of men, women, and children, but denying or limiting the availability of medical rehabilitation to people whose very freedom and independence relies on it, I would suggest, is just as inhumane. Yet it happens here in the United States every day.

I can understand that managed care providers focus on short-term cost savings. They are running a business and operate on an annual basis. But as lawmakers, you can see the folly of this. When benefits run out, the traumatically ill or injured person is laid off to long-term care at greater cost to society.

We can save money in the long run by relieving managed care providers from having to cover the expenses of traumatically ill and injured people. We can create a system of reinsurance and bring in case managers who stick with these people until they achieve inde-

pendent, productive, and healthy life-styles—goals they have set for themselves and achieved thanks to the teams of skilled professionals who support medical rehabilitation all along the way.

In my case, my progress is a result of 2 years of extensive medical rehabilitation. My experience has taught me that you cannot assign arbitrary costs and time limits to the medical rehabilitation process. Human potential is limitless. I have a sign in my office. It reads, "Difficult things take a long time, the impossible takes a little longer."

Please think about all of us speaking to you here today, and especially about the children with whole productive lives ahead of them.

A personal statement and something that may ring home to all of you: Injury does not discriminate. I have proved that none of us—and I am not trying to be smug when I say this. None of us is bulletproof. It can happen to any one of us, this debilitating injury that happened to me. God forbid, anybody on this committee, their loved ones, that it would happen to them. Because of medical rehabilitation, I am able to walk through this door today and am capable and independent and able to address you.

Please ensure that medical rehabilitation will be available to all Americans.

I thank you.

[The prepared statement follows:]



**STATEMENT OF THE  
MEDICAL REHABILITATION EDUCATION FOUNDATION**

**BEFORE THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES  
ON**

**HEALTH CARE REFORM AND A STANDARD BENEFIT PACKAGE**

**April 22, 1993**

Mr. Chairman, and Members of the Subcommittee: I am Steve Palermo, an umpire in the American Baseball League whose life has been significantly improved through medical rehabilitation. I am appearing today on behalf of the Medical Rehabilitation Education Foundation, a nonprofit organization created in 1992 to increase public awareness and understanding of the value of medical rehabilitation.

This Subcommittee faces an awesome task. . . to help restructure -- or reinvent -- the entire health care system of our country to insure its availability to all Americans. I am honored to be able to take part in this effort, and hope that my experience will in some small way help others.

About two years ago, friends and I tried to help two women who were being attacked in a parking lot. To make a long story short, I was shot in the back by the attackers. The bullet cut my spinal cord, and my legs were paralyzed. The doctors told me I would never walk again. . . but I walked in here today.

I've spent the last two years undergoing intensive medical rehabilitation, and you can see the results. The Medical Rehabilitation Education Foundation will submit a detailed report, with facts and statistics, for the hearing record. I will address some key points:

- Medical rehabilitation improves quality of life. It returns persons who become disabled from trauma or disease to the most independent lifestyle possible.

- As a result of medical rehabilitation an estimated 350,000 Americans return to work each year. This results in savings of one to two billion dollars per year for public programs such as workers compensation, disability insurance and Medicaid. In time, I'll be back on the field. . . paying federal and state income taxes instead of running up medical bills. And I will not be receiving social security disability benefits as I am currently from the U.S. government.

- Medical rehabilitation reduces hospital readmissions and extended care readmissions. Fifty to a hundred thousand people return home each year. Without rehabilitation, these people would require expensive long-term care.

- Medical rehabilitation is cost effective, saving hundreds of millions of dollars a year in medical bills.

From my first hand experience, medical rehabilitation is not an option, it is a necessity.

Access to inpatient and outpatient rehabilitation care, and community-based medical rehabilitation services, must be part of the basic health care reform package offered all Americans, in any legislation enacted by Congress.

One final point. Time is both an ally and an enemy to medical rehabilitation. I've been lucky enough to receive all the rehabilitation necessary in the past two years. Time has been my ally.

But I've met other patients, including children, where time was the enemy. Their progress was interrupted because their benefits ran out. They had to wait, lose momentum and quite often regress, because their insurance wouldn't cover additional weeks of rehabilitation. Some patients reach the lifetime cap for their condition, and are doomed to spend the rest of their lives never reaching their full potential for rehabilitation.

We become outraged when we see news on television of inhumane treatment of men, women and children, but denying or limiting the availability of medical rehabilitation to people whose very freedom and independence relies on it, I would suggest, is just as inhumane. Yet it happens here in the United States every day.

I can understand that managed care providers focus on short-term cost savings. They are running a business, and operate on an annual basis. But as lawmakers, you can see the folly of this. When benefits run out the traumatically ill or injured person is laid off to long-term care, at much greater cost to society.

We can save money in the long run by relieving managed care providers from having to cover the expenses of traumatically ill and injured people. We can create a system of reinsurance, and bring in case managers who stick with these people until they achieve independent, productive and healthy lifestyles -- goals they've set for themselves and achieved thanks to the teams of skilled professionals who support medical rehabilitation all along the way.

In my case, my progress is the result of two years of extensive medical rehabilitation. My experience has taught me that you cannot assign arbitrary cost and time limits to the medical rehabilitation process: human potential is limitless. I have a sign in my office, it says, difficult things take a long time, the impossible takes a little longer.

Please think about all of us speaking to you here today, and especially on the children with whole productive lives ahead of them. Please insure that medical rehabilitation will be available to all Americans.

Thank you.

[A STUDY ATTACHED TO THIS STATEMENT ENTITLED, "MEDICAL REHABILITATION AND PUBLIC POLICY," PREPARED BY RAND SNELL, IS BEING RETAINED IN THE COMMITTEE FILES.]

## PUBLIC POLICY BENEFITS OF MEDICAL REHABILITATION

### Key Talking Points

Medical rehabilitation combats disability, which the Institute of Medicine calls the principle public healthcare problem in the United States.

- 35 million Americans have ongoing disabling conditions and the average American will live almost 13 years with some sort of disability.
- Disability payments by government and industry are expected to top \$200 billion annually by the year 2,000.
- Improvements in acute medical care and increasing longevity will cause the disability problem to worsen as the U.S. population ages.
- Even with the best prevention strategies, disabling injury and disease will continue as the United States' principle public healthcare problem and rehabilitation provides the only tools to deal with that problem.

Medical Rehabilitation saves money by reducing medical and nursing home costs, halting progression of primary and secondary disabilities and returning people to productive employment.

- Nursing home savings alone range between \$500 million and \$1 billion annually. Cost savings from reduced hospital stays are in hundreds of millions of dollars, with hospital stays for disabilities such as head injury reduced between one half and one third.
- Savings in long-term disability costs range from \$1 billion to \$2 billion annually, with an insurance industry-wide survey showing an average \$11 savings for \$1 in rehabilitation.
- Increased earning power due to rehabilitation results in an additional \$3.5 billion income annually, with resultant tax revenues of approximately \$700 million. State studies indicate a return of over \$7 per \$1 invested.



Medical Rehabilitation restores and maintains a healthy quality of life for victims of injury and disabling disease. Approximately 350,000 people a year return to work thanks to rehabilitation.

- Rehabilitation helps to reduce the effects of injury and chronic disease,
- restores functional ability and helps victims cope with ongoing disability, and
- helps maintain health, thus extending life and reducing subsequent illness.

For growing numbers of elderly and working age Americans saved from death by advances in acute medical care, rehabilitation provides the only hope for meaningful life.

- They return home rather than to nursing homes,
- are independent, rather than dependent on family or other care givers, and
- avoid costly secondary disabilities.

Medical Rehabilitation is an integral part of basic healthcare services. Access to inpatient and outpatient rehabilitation care and to community based medical rehabilitation services should be a central part of the basic healthcare package offered all Americans in any national healthcare reform package enacted by Congress.

- Acute care saves lives, but medical rehabilitation can determine the future quality of life, future employability, and can deter secondary disabilities.
- The earlier medical rehabilitation begins, the better the results. It should be integrated into initial, acute care of injury and disabling disease. This is dramatized by traumatic head and spinal injuries to young people, such as the 1992 paralysis of New York Jets defensive lineman Dennis Byrd. But it is also true for older patients, including victims of strokes and disabling disease.

- Medical rehabilitation works and it saves money. But of the 72 million Americans now living who have experienced serious injury, stroke or other disabling disease, more than 60% never received rehabilitation. Only 6.6% of severely impaired SSDI applicants ever receive any physical or occupational therapy, and only 21% of patients in a recent hospital survey completed inpatient rehabilitation. Significant economic and social benefits remain to be achieved through broader access to medical rehabilitation.

Medical Rehabilitation complements and augments goals of the Americans with Disabilities Act.

- As barriers to employment and involvement in mainstream life come down, people with permanent disabilities will have greater opportunity to profit from regained or increased functional skills. But since even now the majority of people who could benefit from rehabilitation do not receive it, access will have to be expanded.

Mr. ANDREWS. Thank you, Mr. Palermo.  
Ms. Wildy.

**STATEMENT OF JODY WILDY, NATIONAL REHABILITATION  
CAUCUS, WASHINGTON, D.C.**

Ms. WILDY. Mr. Chairman, I am Jody Wildy. I am appearing today on behalf of the National Rehabilitation Caucus. The NRC is a coalition of organizations representing rehabilitation providers, consumers, and suppliers as well as various national providers of rehabilitation services.

I am living my life, back at work, and socializing with my family and friends because of rehab. It is cost-effective. It makes sure people have productive lives. It is a part of today's health care system. It is covered by most major commercial insurance policies and Medicare and Medicaid. Inpatient and outpatient rehab services and community-based rehab services must be a part of tomorrow's health care system by being included in a standard benefit package.

Let me tell you briefly what happened to me as one of the over 4 million people a year who benefit from rehab. I was helping someone with a flat tire. I was hit by a drunk driver who had minimal insurance. I lost one leg on impact, and the other was so severely damaged it had to be amputated.

My insurance, an HMO, paid for the surgery. It would also pay for a limited rehab benefit, 60 days, but it would not pay for the new legs I needed, the bandages, crutches, or a wheelchair. My HMO wanted me to go to the rehab center it had under contract. An employee at the center told me that if I got my legs, I wouldn't use them. I rebelled. I have worked very hard to go to school, to own a home, and to have a series of responsible jobs. I wasn't going to let anyone throw that away.

I worked hard to get into a freestanding rehab hospital here when I was ready for rehab. After 3 days at rehab, we agreed that I should not use up my 60-day benefit until I had my legs. So I started another campaign that resulted in being eligible for a State vocational rehab program which paid for my legs. This took 5 months. Five months of sitting at home, paying for a wheelchair that my insurance did not cover. Five months when I could have had rehab and been back to work. Five months when complications developed that then had to be fixed when I was finally able to go to rehab.

Let me mention what rehab is all about. Rehab involves specialized physicians, rehab nurses, numerous therapists, and social workers, among others, who work as a team to increase and return the patient's functional ability and ability to be independent. This team concept is central to rehab, and the sum of these efforts is greater than the parts. It is called an interdisciplinary team, and it works.

Rehab is delivered in a number of places—freestanding rehab hospitals, like the one I went to; rehab units of general hospitals; comprehensive outpatient rehab facilities; rehab agencies; and other outpatient settings—by independent practitioners, nursing facilities, and home health agencies. Which setting is appropriate is a function of medical judgment.



Well, finally I went to rehab and was told by my insurance company it would pay a stated amount for the rehab. If I used the money before the 60 days was up, I had to pay for the balance. If I got to the 60 days and hadn't completed my program before the money ran out, it would also stop paying.

I went to work at rehab, and I worked hard, and I still am. But I am now back at work. Mr. Chairman, if I had not received rehabilitation services, I would be a tax user, not a taxpayer.

It is good policy and good health care to continue to include and recognize rehab in tomorrow's standard benefit package. This is true for a number of reasons because: Rehabilitation services improve people's lives and productivity; rehabilitation services are cost-effective. Studies show that for every dollar spent on rehabilitation, at least \$11 are saved; rehabilitation outcomes can be measured.

Our recommendations are: That Congress retain the authority to establish a benefits package; one, that a standard benefit package must continue to include the full range of rehab services to help people improve functioning and lead productive lives. The range of benefits covered by most major commercial insurance policies and Medicare represent good starting point and, for people like me, must include the needed prostheses; two, that rehabilitation services should be covered in every setting deemed appropriate based on a person's functional status; and three, that the benefit package be able to evolve to respond to new cost-effective prevention and treatment approaches.

Mr. Chairman, I am living proof of how rehabilitation works. Again, thank you for this opportunity, and I will be pleased to answer any questions.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL REHABILITATION CAUCUS  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
APRIL 22, 1993

Mr. Chairman:

I am Jody Wildy. I am appearing today on behalf of the National Rehabilitation Caucus (NRC). The NRC is a coalition of organizations representing rehabilitation providers, consumers, and suppliers as well as various national providers of rehabilitation services. Founded in 1984, the NRC provides a national focus for the advancement of rehabilitation through advocacy, education, research, and communications.

You and your committee have a great responsibility and opportunity in reinventing health care for America. I appreciate the opportunity to appear before you today.

I am submitting our complete statement for the record. In summary I am living my life, back at work, and socializing with my family and friends because of rehabilitation. It is cost effective. It makes sure people have productive lives. It is part of today's health care system. It is covered by most major commercial insurance policies and Medicare and Medicaid. Inpatient and outpatient rehabilitation services and community based rehabilitation services must be part of tomorrow's health care system as part of a standard benefit package.

Let me tell you briefly what happened to me as one of the over four million people a year who benefit from rehab. Over a year ago I was helping someone with a flat tire. I was hit by a drunk driver who had minimal insurance. I lost one leg on impact; the other was so badly damaged it had to be amputated.

My insurance, an HMO, paid for the surgery. It would also pay for a limited rehabilitation benefit - 60 days, but it would not pay for the new legs I needed to walk again, bandages to prepare me for rehab, or a wheelchair. My HMO wanted me to go to the rehabilitation center it had under contract. A person at the center told me that if I got the legs, I wouldn't use them! I rebelled. I have worked very hard in my life to go to school, to own a home, and to have a series of responsible jobs. I wasn't going to let anyone throw it away.

So, I worked hard to get into a freestanding rehabilitation hospital here. After I was out of the general hospital, I was ready for rehab. After three days at rehab we agreed that I should not use up my 60 day benefit until I had legs. So I started another campaign that resulted in being eligible for a state vocational rehabilitation program, which paid for my legs. This took 5 months. Five months of sitting at home, paying for a wheelchair that my insurance did not cover. Five months when I could have had rehabilitation and been back to work. Five months when complications developed by sitting at home that then had to be fixed when I was finally able to go to rehab.

Let me mention what rehab is all about. Rehabilitation involves specialized physicians, rehabilitation nurses, numerous therapists, and social workers, among others who work as a complete team with patients to increase their functional ability and to help them be independent. The team concept is central to rehabilitation and the sum of these efforts is greater than the parts. In rehab lingo we call it an interdisciplinary team. And it works. Rehab is delivered in a number of places - freestanding rehabilitation hospitals like I went to, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, by independent

practitioners, nursing facilities, and home health agencies. Which setting is appropriate is a function of medical judgement.

Well, finally I went to rehabilitation and was told by my insurance company it would pay a stated amount for the rehab. If I used the money before the 60 days was up I had to pay for the balance. If I got to 60 days and hadn't completed my program before the money ran out, it would also stop paying.

I went to work at rehab and I worked hard and still am -- but I am now back at work! And, I have switched insurance companies to one that is more of a help to me. Mr. Chairman, if I had not received rehabilitation services, I would be a tax user, not a tax payer.

In summary I want to say:

It is good policy and good health care to continue to include and recognize rehabilitation in tomorrow's standard benefit package. This is true for a number of personal reasons, such as for myself, and financially because:

- \* Rehabilitation services improves people's lives and productivity.
- \* Rehabilitation services are cost effective. Studies show that for every dollar spent on rehabilitation, at least \$11 are saved.
- \* Rehabilitation outcomes can be measured.

Our recommendations are:

1. That Congress retain the authority to establish a benefits package.
2. That a standard benefits package must continue to include the full range of rehabilitation services to help people improve functioning and lead productive lives. The range of benefits covered by most major commercial insurance policies and Medicare represent good starting points, and for people like me, must include the needed prostheses!
3. That rehabilitation services should be covered in every setting deemed appropriate based on the person's functional status.
4. That the benefit package be able to evolve to respond to new, cost effective prevention and treatment approaches.

Mr. Chairman, again, thank you for this opportunity. I would be pleased to answer questions.

Attachments:

1. List of members of the National Rehabilitation Caucus and National Rehabilitation Providers supporting the NRC Policy Paper.
2. Coverage of Rehabilitation Services and Cost Effectiveness of Rehabilitation Services.



## REHABILITATION: AN ESSENTIAL COMPONENT OF HEALTH CARE

A POSITION PAPER

DEVELOPED BY

THE FOLLOWING PARTICIPANTS OF THE NATIONAL REHABILITATION CAUCUS

American Academy of Physical Medicine and Rehabilitation; American Association for Respiratory Care; American Congress of Rehabilitation Medicine; American Occupational Therapy Association; American Pain Society; American Physical Therapy Association; American Speech-Language-Hearing Association; Association of Rehabilitation Nurses; National Association for the Support of Long Term Care; National Association of Medical Equipment Suppliers; National Association of Rehabilitation Agencies; National Association of Rehabilitation Facilities; National Committee to Preserve Social Security and Medicare; National Head Injury Foundation; National Stroke Association; Private Practice Section, American Physical Therapy Association; American Therapeutic Recreation Association; National Rehabilitation Counseling Association; United Cerebral Palsy Association

AND

THE FOLLOWING NATIONAL PROVIDERS OF REHABILITATION SERVICES

Communi-Care of America, Inc.; Comprehensive Rehabilitation of America, Inc.; Continental Medical Systems, Inc.; HEALTHSOUTH Rehabilitation Corp.; NovaCare, Inc.; Pro-Rehab, Inc.; RehabClinics, Inc.; Rehabworks, Inc.; Healthtek Rehabilitation, Inc.; Associated Health Focus, Inc.

AND

ACCREDITING ORGANIZATIONS

Commission on Accreditation of Rehabilitation Facilities

JANUARY 1993

## COVERAGE OF REHABILITATION SERVICES AND COST EFFECTIVENESS OF REHABILITATION SERVICES

### I. COVERAGE OF REHABILITATION SERVICES

As Congress undertakes the daunting task of reforming the nation's health care system, it must ensure that rehabilitation is retained in the basic health care package available to all individuals. Rehabilitation is an integral part of the health care delivery system and should continue to be supported.

#### *Coverage of Rehabilitation Services is Standard in Today's Insurance System*

Rehabilitation services are a standard benefit in most health insurance packages currently offered by both public and private payers. Americans have come to expect that the range of therapies needed to improve their functional capacity and autonomy will be provided. Notwithstanding the wide diversity of health care payers in the U.S., virtually all of them cover rehabilitation therapy in one form or another. This is true in both the public and private sectors.

- **Medicare** -- The federal Medicare program covers occupational and physical therapy, speech-language pathology and audiology, respiratory therapy, social work services, rehabilitation nursing and psychiatry in a range of inpatient and outpatient settings. The program also provides coverage of items that are frequently essential to rehabilitation care including orthotics (splints), prosthetics (limbs), and durable medical equipment. Providers recognized under Medicare include rehabilitation hospitals, rehabilitation units in general hospitals, rehabilitation agencies, clinics, nursing facilities, CORFs, home health agencies, home medical equipment suppliers, and independent practitioners.
- **Medicaid** -- Rehabilitation services also are widely covered within the Medicaid program. Every state Medicaid plan covers rehabilitation services when provided within a hospital (both inpatient and outpatient), nursing facility, home care, or under the Early and Periodic Screening, Detection and Treatment (EPSDT) program, since coverage of each of these benefits is mandatory under federal law. With respect to optional Medicaid benefits, rehabilitation services may be covered when provided by clinics, rehabilitation agencies, CORFs, and independent practitioners. Most states have chosen to furnish rehabilitation services in these optional settings.

- **Black Lung** -- The Black Lung Program, which provides federal assistance to coal miners and their dependents, has covered and reimbursed outpatient pulmonary rehabilitation since 1978.
- **State Mandatory Coverage Laws** -- Several states have enacted legislation mandating coverage for specific rehabilitative services. For example, Delaware and Louisiana have recently passed laws requiring coverage of physical therapy, speech-language pathology and audiology services, and occupational therapy. Rehabilitation services are mandatory in one form or another in Connecticut, Maine, Massachusetts, West Virginia, Missouri, Texas, Tennessee and Arkansas.
- **Private Insurance** -- The private health insurance industry also routinely offers coverage of rehabilitation services. While insurers may limit the number of rehabilitation visits covered or apply an annual monetary cap, very few limit coverage by specific diagnosis or clinical indication. Most plans require that rehabilitation services be ordered by a physician and furnished by providers having specific credentials. For example, many plans will cover physical therapy only if provided by a licensed physical therapist.
- **Blue Cross/Blue Shield Plans** -- Based on an informal national survey by this Coalition, it is clear that respiratory therapy, speech-language pathology services, audiology, and physical and occupational therapy services are commonly covered by the Blue Cross/Blue Shield plans in the country. In particular, while the scope of coverage varies by plan and insurance product, physical and occupational therapy are routinely covered, and speech-language pathology services and respiratory therapy are usually covered subject to certain limitations (e.g., limited diagnoses, time periods, and/or settings).
- **HMOs** -- Coverage of rehabilitation therapy is also well-established within the HMO market. The annual HMO Industry Survey conducted by the Group Health Association of America confirms that virtually all HMOs, regardless of their federal qualification status, cover rehabilitation services as part of their best-selling benefit package.

## II. COST EFFECTIVENESS OF REHABILITATION SERVICES

Expenditures made for rehabilitation services are investments in human capital. Rehabilitation intervention to remediate functional impairment caused by illness, disease or injury results in a reduction in the cost of care. This has been verified in a number of studies and surveys conducted by the insurance industry over the



past several years. For example, a survey conducted by the Health Insurance Association of America (HIAA) of member companies reported a savings of \$11 for every \$1 spent on rehabilitation, with "a savings per claimant ranging from \$1,500 to over \$250,000." Other studies have confirmed that early rehabilitation for stroke and traumatic brain injury lead to shorter overall hospitalization, less mortality and fewer complications, that comprehensive rehabilitation programs are effective in treating low back pain, and that pulmonary rehabilitation reduces expensive rehospitalization and emergency room visits.

#### ***Why Rehabilitation Services are Cost-Effective***

Rehabilitation services are viewed as cost-effective for the following reasons:

- ***Rehabilitation services return patients to productive lives*** -- rehabilitation is widely acknowledged as one of the most effective forms of prevention for survivors of serious illness, disease and injury. Through rigorous physical, social and cognitive restoration programs, rehabilitation prevents these survivors from becoming persons with permanent or long-term disabilities. It assures that any residual impairment does not become a disability affecting an individual's activities at work, home, school or play.
- ***Rehabilitation prevents recurrence*** -- Rehabilitation is also well known for its efficacy in preventing complications and subsequent re-hospitalization, which can be very costly. For example, rehabilitation helps prevent deep vein thrombosis, cardiac involvement, pressure ulcers, contractures, pulmonary emboli, and emotional dependence and depression.
- ***Rehabilitation speeds recovery*** -- Several studies have shown that stroke patients who receive rehabilitation have better outcomes than those who do not. Additionally, these studies indicate that stroke rehabilitation patients are more likely to be discharged to home than to a nursing home. They are also likely to live longer and are more likely to retain a higher level of function and activity. A 1981 study found that each stroke patient who, through rehabilitation, has a reduced exposure to lengthy nursing home stays can save the American economy \$17,000 per year.
- ***Rehabilitation maximizes the restoration of functional capacity*** -- Rehabilitation can help consumers adapt to a physical challenge and lead a more independent life. To understand the impact of rehabilitation, it can be helpful to consider a daily example: a consumer's ability to dress independently. Many older spouses and family members do not have the physical strength required to

assist a loved one in this daily routine. The consequences of employing a nurse or aide to assist in this daily process can be costly and discouraging. In a study of 329 rehabilitation patients, 245 required total or maximum assistance to dress on admission. At discharge, 156 required only a minimal level of assistance. If we assume that helping someone dress requires half an hour a day, then the improvement of 156 patients to require only a minimal level of assistance (which could be provided by a spouse or family member) would save 28,470 hours per year. If a minimum wage of \$4.25 applied to each individual needed to help a person dress, an annual savings of \$120,997 could be realized. Similar logic can be applied to the savings that result from a rehabilitation patient's attaining independence in other areas of daily life. These include independent locomotion and the management of bladder skills, which can reduce the risk of infection and the need for further medical intervention.

***Preventive rehabilitation improves workplace productivity***

-- The benefits of rehabilitation do not begin only with the occurrence of an injury, rather they start with injury prevention in the workplace. Through workplace prevention, rehabilitation saves countless health care dollars as well as lost hours of productivity. Some rehabilitation professionals specialize in working with employers to examine work sites, identify hazards and eliminate the potential for work-related injuries. The Public Health Service estimates that in 1989 there were 192 cases of cumulative traumatic disorder (just one kind of work-related injury) per 100,000 workers. These disorders affected workers who engaged in repeated wrist-twisting motions, from computer users to meat cutters to grocery store check-out clerks. The proactive involvement of rehabilitation professionals in the workplace can help reduce the incidence of these cumulative traumatic disorders through the modification of work stations, the analysis and improvement of the motions used in work (particularly in repetitive working situations) and by coaching good lifting techniques. These precautions help prevent workplace injuries and the need for more major medical intervention.

Mr. ANDREWS. Thank you very much for your testimony.  
Ms. Stovall.

**STATEMENT OF ELLEN L. STOVALL, EXECUTIVE DIRECTOR,  
NATIONAL COALITION FOR CANCER SURVIVORSHIP, ON BE-  
HALF OF THE CANCER LEADERSHIP COUNCIL**

Ms. STOVALL. Thank you, Mr. Chairman, and good morning to you. My name is Ellen Stovall, and I am honored to testify before you today as a cancer survivor of more than 21 years. I am one of the more than 8 million people living in this country today who have received the devastating diagnosis of cancer. Like many other millions, I too have experienced several of the shortcomings of our current health care system. For example, because of my history of cancer, I am unable to purchase insurance without either paying an unaffordable premium or enduring a lengthy waiting period, a situation that was exacerbated when my husband lost his job last year due to the recent economic downturn.

Not incidentally, I am also here today in my capacity as executive director of the National Coalition for Cancer Survivorship. Because people with cancer confront problems like mine on a daily basis, a number of leading cancer patient and advocacy organizations came together to develop a consensus statement to guide the discussion of health care reform.

These organizations collectively serve several hundred thousand people whose lives literally depend on a health care delivery and reimbursement system that does not compromise their ability to receive state-of-the-art cancer treatment. In addition to NCCS, this alliance for health care reform is made up of Cancer Care, Inc., the Candelighters Childhood Cancer Foundation, the Susan G. Komen Foundation, the National Alliance of Breast Cancer Organizations, US TOO and Y-ME, and is known as the Cancer Leadership Council.

We believe that several elements are essential, including mental health services to address the devastating psychosocial consequences of a cancer diagnosis, as well as rehabilitation services to treat the short- and long-term physical effects that often result from cancer treatment. Maintaining our choice of our oncologist to treat our cancer, as well as coverage for home and hospice care are also critical ingredients.

In the time remaining, however, I would like to highlight two benefits that are uniquely essential to one in three Americans who will get cancer: the patient care costs associated with clinical trials and unlabeled uses of approved cancer therapies.

When most people hear they have cancer, they immediately seek treatments offering hope for a complete recovery. However, all too many will soon learn that such a cure is not yet available to them. For them, clinical trials utilizing new therapies or novel combinations of approved anticancer drugs often represent state-of-the-art cancer treatment.

Presently, however, many insurers refuse to reimburse the patient care costs which result from participating in clinical trials. Instead, they claim that such therapy is "investigational" or "experimental." When this happens, individuals cannot receive what potentially may be the best treatment for their condition unless they



can afford to pay significant out-of-pocket expenses, often running into thousands of dollars. Unless these patient care costs are included in a standard benefits package, it is likely that the reform system will evolve into one with two tiers of care, potentially one in which only the wealthy have access to the best anticancer treatments.

We have suggested a number of criteria to describe the types of trials for which reimbursement should be available, including the existence of a rigorous peer review process so that ethical safeguards are in place. Providing reimbursement for these types of clinical trial costs will enable all cancer patients to have equal access to the most promising treatments. At the same time, we will be generating the clinical data necessary to make significant progress in the war against cancer.

Another hurdle to receiving the best treatment for cancer is the frequent refusal of insurers to reimburse so-called unlabeled uses of approved anticancer drugs. Again, insurers typically base these denials on exclusions for experimental or investigational therapy.

Unlabeled uses are indications that are not included on a drug's FDA-approved label. As much as one-half to three-fourths of anticancer drug treatment falls within this category.

As this simple statistic shows, unlabeled indications are not investigational or experimental. Instead, they are an important and necessary part of cancer treatment and customarily are prescribed by oncologists often because they represent the best possible therapy. Therefore, we believe unlabeled indications should be covered under a standard benefits package where supported by the medical compendia or the peer-reviewed literature.

In concluding, I want to leave you with one thought: The reform of our health care system, including the designation of a standard benefits package, is not simply an exercise in abstract theory. The decisions made by you, your colleagues in Congress, and the administration will result in very real consequences for all of the people in this country who either have, have had, or will have cancer. That is 8 million people today, or 1 in 3 Americans, some of whom are sitting in this room. Unlike any other life-threatening disease, cancer will touch the lives of each and every one of us in this country.

With that sobering thought, I ask all of you to study carefully the statement crafted by the Cancer Leadership Council. Although the principles set forth were developed from the viewpoint of people with cancer, they have been ratified by many other sectors of the cancer community, including the American Society of Clinical Oncology, the National Coalition for Cancer Research, and the Oncology Nursing Society.

Thank you for holding this important hearing. I would be pleased to answer any questions.

[The prepared statement follows:]

**TESTIMONY OF ELLEN L. STOVALL**  
**National Coalition for Cancer Survivorship**

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Ellen Stovall, and I am honored to testify before you today as a cancer survivor of more than 21 years. I am one of more than eight million Americans living today who have received the devastating diagnosis of cancer; like many other millions, I also have experienced several of the shortcomings of our current health care system. For example, I am now unable to purchase insurance without either paying a prohibitively high premium or enduring a lengthy waiting period before coverage begins -- a situation exacerbated when my husband lost his job last year due to the recent economic downturn here in D.C.

**The Cancer Leadership Council**

Not incidentally, I am also here today in my capacity as Executive Director of the National Coalition for Cancer Survivorship (NCCS). As a result of problems similar to mine which confront people with cancer on a daily basis, a number of leading cancer patient organizations came together to develop a consensus statement to guide this country's deliberations on health care reform. This unprecedented collaboration of seven otherwise diverse cancer patient and advocacy groups was motivated by our shared belief that there is no other single issue of more importance to the eight million Americans living today who have heard the dreaded words "you have cancer."

These organizations collectively serve several hundred thousand people whose lives literally depend on a health care delivery and reimbursement system that does not compromise their ability to access state-of-the-art cancer treatment. In addition to NCCS, Cancer Care, Inc., Candlelighters Childhood Cancer Foundation, The Susan G. Komen Foundation, the National Alliance of Breast Cancer Organizations (NABCO), US TOO, and Y-ME National Organization for Breast Cancer Information and Support, Inc. (Y-ME) make up this alliance for health care reform which is known as the Cancer Leadership Council.

People with cancer are hopeful that this country is on the brink of meaningful reform of its health care system. We believe that inadequate access to health care is a fundamental problem that must be addressed by reform measures. However, access is only a part of this complicated picture. Just as important is the scope of any standard benefits

package -- particularly in the case of chronic, life-threatening illnesses like cancer, where progression of the disease means that patients will require different treatments and services depending on the stage of their illness.

In the time remaining to me, I would like to highlight several benefits that we on the front lines of the battle against cancer feel must be included in any standard benefits package if the one in three Americans who will be diagnosed with cancer are to receive adequate medical care.

### **Reimbursement of Patient Care Costs Associated with Clinical Trials**

After hearing the news that they have cancer, most people immediately seek those treatments offering the most hope for a complete recovery. Despite the significant progress that has been made in the treatment of this disease since passage of the National Cancer Act more than 20 years ago, all too many will learn that a complete cure is not yet available for their particular type of cancer. For them, clinical trials utilizing new therapies or combining novel therapeutic regimens of approved anticancer agents often represent state-of-the-art cancer treatment.

The importance of clinical trials has touched me in a personal way because if not for the therapeutic advances made possible through clinical trials, I would have had little chance to recover from cancer. When I had a recurrence of cancer in 1984, I was treated pursuant to a protocol that was developed through a clinical trial in effect when I was first diagnosed in 1971; this treatment is still considered standard therapy for my type of cancer.

Presently, however, many insurers ignore this reality and refuse to reimburse the patient care costs which result from participating in clinical trials. Typically, insurers justify their denials by citing exceptions for "investigational" or "experimental" treatment. When this happens, individuals with cancer often are denied access to what may constitute the best treatment for them unless they can afford to pay significant out-of-pocket expenses which can run into thousands of dollars. If standard benefits packages fail to recognize the legitimate role played by clinical trials in the care of persons with cancer, then it is likely that a two-tiered system of care will result, with only the wealthy having access to the most promising anticancer treatments.



Clinical trials also play a pivotal role in the treatment of children with cancer. In fact, most of these children receive treatment pursuant to clinical trial protocols, and as a result can look forward to long and productive lives. Thus, inclusion of patient care costs in a standard benefits package also is consistent with this nation's increased appreciation of the importance of childhood health measures.

We have suggested a number of criteria to describe the types of trials for which reimbursement should be available. Particularly important is the existence of a rigorous peer review process, so that we are assured that patients are receiving care in accordance with established ethical principles through trials that are as likely to result in meaningful benefit as currently available therapy. Providing reimbursement for these types of clinical trial costs will enable all cancer patients to have equal access to the most promising treatments while allowing us to collect the necessary scientific data to make significant progress in the war against cancer.

### **Reimbursement of Medically Appropriate Unlabeled Uses of Approved Anticancer Drugs**

Another hurdle to receiving the best treatment for cancer is the frequent refusal of insurers to reimburse so-called "unlabeled" uses of approved anticancer drugs, again on the basis of exclusions for experimental or investigational therapy.

Although anticancer drugs typically are approved by the Food & Drug Administration for a limited number of narrow indications, they usually are effective against a number of other tumor types, resulting in the widespread use of these drugs for unlabeled indications; as much as one-half to three-fourths of anticancer drug treatment falls into this category.

Far from being investigational or experimental, unlabeled uses of approved anticancer drugs are an important and necessary part of cancer treatment, and customarily are prescribed by oncologists as they frequently represent the best therapy available. Therefore, unlabeled indications should be covered under a standard benefits package where supported by references in the medical compendia or the peer-reviewed literature.

### **Mental Health and Rehabilitation Services**

Thus far, I have focused on the unique treatment needs of persons with cancer in terms of battling the disease itself. However, it is imperative that we also recognize the devastating psychosocial and physical consequences which often accompany a diagnosis of cancer.

Cancer imposes a devastating psychosocial burden on persons with cancer as well as their loved ones -- relationships within the family, on the job, and in the community are suddenly and irrevocably changed in a manner that can be difficult to manage without professional assistance. Additionally, many treatments for cancer leave survivors with short and long term physical effects that require rehabilitative services.

Therefore, if people with cancer are to lead full and active lives, their ability to access and receive mental health and rehabilitation services must be ensured by including them in a standard benefits package.

### **Hospice, Home Health and Related Services**

Sadly, we also must recognize that the goal of a complete recovery may be beyond the reach of many individuals with cancer -- at the present time, cancer claims the lives of one in four Americans. Persons in the last stages of cancer and members of their families have special needs so that they are able to make this final journey in a serene and dignified manner. For these people, services such as hospice and home health care can mean the difference between dying alone in a strange environment versus living their remaining days in peace -- either in a caring environment such as a hospice facility, or in their home, surrounded by their family and friends.

Given these choices, the inclusion of hospice, home health and related services in a standard benefits package is important to people with cancer.

## Conclusion

In concluding my remarks, I cannot over-emphasize that the reform of our health care system, including the design of a standard benefits package, is not an exercise in abstract theory. The decisions made by you, your colleagues in Congress, and the Administration, will result in very real consequences for all of the people in this country who either have, have had, or will have cancer -- that's eight million people today, or one in three Americans. Unlike any other life-threatening disease, cancer will touch each and every one of our lives.

With that sobering thought, I ask all of you to study carefully the statement crafted by the Cancer Leadership Council. Although the principles set forth in this statement were developed from the viewpoint of people with cancer, they have been ratified by many other sectors of the cancer community, including several professional organizations such as the American Society of Clinical Oncology, the National Coalition for Cancer Research, and the Oncology Nursing Society.

Thank you again for holding this important hearing. I will be glad to answer any questions you may have at the appropriate time.



## Cancer Leadership Council's Statement on Health Care Reform

There is an urgent need for major health care reform to improve the accessibility and affordability of health insurance and health care for all Americans. American cancer patients have had access to some of the most advanced medical technology available in the world. At the same time, we have been exposed to some of the greatest failings of the current U.S. system. Cancer now strikes one in three Americans and kills one in four. Based on our first-hand experience with the current system of care, we propose a series of recommendations (see below) as essential components of a health care reform package.

These recommendations are not intended as a comprehensive statement of all necessary reform measures; however, they do represent consensus on those issues for which our experience offers a unique perspective.

In addition to these recommendations, proposals for national health care reform must (at a minimum) contain costs by seeking to enhance administrative efficiency, reduce unnecessary or ineffective care, and encourage personal responsibility for good health. However, while cost containment measures are an inevitable component of health care reform, measures that will eliminate or jeopardize access to essential services for all Americans are insupportable. Cost-containment measures that fail to acknowledge the necessity for comprehensive, high quality cancer services, as well as their long-term cost-effectiveness, would contradict the overall objectives of health care reform.

### ELIGIBILITY

**Discrimination Based on Health Status:** Health insurance should be available to all persons at a reasonable price regardless of their health status or medical history, occupation, or other risk factors. The use of experience rating to establish premiums should be forbidden.

### COVERAGE AND BENEFITS

**Pre-Existing Conditions:** The use of pre-existing condition clauses should be declared an unfair insurance practice as it relates to those persons who are already covered by insurance and need to change plans; or at least regulated to assure that they are not used to deprive consumers of fair insurance coverage.

**Catastrophic Expenses:** All health care reform measures should ensure that individuals and families are protected from devastating out-of-pocket medical expenses arising from catastrophic illnesses.

**Adequate Coverage for Anti-Cancer Drugs:** Reimbursement for therapies, including associated hospital and physician costs, should be available for any FDA-approved anti-cancer drug for any medically appropriate indication (as reflected in standard medical compendia or peer-reviewed literature.)

**Coverage of Investigational Treatment:** Reimbursement for new therapies still under investigation should be available when the following circumstances are present:

- a) Treatment is being provided pursuant to a clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an Investigational New Drug (IND) exemption; the Department of Veteran Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants; and
- b) The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB); and
- c) The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training; and
- d) The patients receiving the investigational treatment meet all protocol requirements; and
- e) There is no clearly superior, noninvestigational alternative to the protocol treatment; and
- f) The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the alternative.

**Preventive and Early Detection Services:** Adequate reimbursement should be available for effective primary preventive measures (such as childhood immunizations) and early detection health measures (such as mammography for breast cancer and PSA testing for prostate cancer).

**Adequate Coverage of Mental Health & Rehabilitation Services & Therapies:** Reimbursement routinely should extend to mental health and rehabilitative services rendered by health care professionals as part of a comprehensive treatment plan addressing both the physical and mental consequences of cancer.

**Hospice, Home Health and Related Services:** Any basic package of benefits should be at least as comprehensive as those currently provided under Medicare, including coverage for such services as home health or hospice care.

**Self-Insured Employer Plans:** Health care reform measures must apply to all individuals, including those covered through self-insured plans.

**Choice of Providers:** The continued ability of individuals to choose among qualified providers and a range of specialists must be reflected in any health care reform proposal. If a network of providers is restricted, then provision must be made for care outside of the network.

## **INDIVIDUAL RESPONSIBILITY FOR GOOD HEALTH**

**Promotion of Good Health:** Any health reform measure should include educational programs designed to promote healthy lifestyle choices and significantly increased excise taxes on tobacco and other products known to cause cancer so as to deter their use.

# Cancer Leadership Council

*Advocating for Health Care Reform*

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## BACKGROUND AND SUMMARY

The Cancer Leadership Council is comprised of organizations dedicated to advancing the concerns of people with cancer during the debate on health care reform. Health care reform is critically important to our constituents, who have first-hand knowledge of both the best and worst aspects of our current health care system. The attached Statement on Health Care Reform reflects the Council's consensus opinion as to the minimum basic requirements which any health care reform measures should include. The individual members of the Council and a brief description of their missions are listed below:

### The National Coalition for Cancer Survivorship (NCCS)

NCCS is a nonprofit consumer organization whose mission is to advocate on behalf of people with all types of cancer. NCCS is the largest national umbrella group representing the interests of hundreds of grassroots cancer support and advocacy groups, most of this country's leading cancer treatment institutions, and many of the more than eight million individuals living in the U.S. with a diagnosis of cancer.

### Cancer Care, Inc.

Cancer Care is a nonprofit, nonsectarian, social service agency established in 1944 to help patients and families cope with the consequences of cancer. Services include professional counseling, financial assistance, educational programs, information and referral, entitlement and insurance counseling, and are provided at no charge to the client. Last year, 35,000 individuals were reached through five office locations in the New York, New Jersey and Connecticut tri-state region.

### Candlelighters Childhood Cancer Foundation

Candlelighters works to educate, support, serve and advocate for families of children with cancer, survivors of childhood cancer, and the professionals who serve them. With a membership of nearly 40,000 and as a recognized leader in the field of pediatric oncology, Candlelighters is the only organization of its kind focusing on the effects of childhood cancer through a cooperative effort by parents and professionals.

### The Susan G. Komen Foundation

The Susan G. Komen Breast Cancer Foundation is a national volunteer organization whose mission is to eradicate breast cancer as a life threatening disease by advancing research, education, screening and treatment. Through its Chapters and/or Race for the Cure sites in 24 states and 37 cities nationwide, the Komen Foundation funds research and grants and community-based screening, education and awareness programs for women who are medically underserved, low-income and members of minority groups.

### National Alliance of Breast Cancer Organizations (NABCO)

NABCO is a nonprofit organization that provides health organizations and individuals with up-to-date information about breast cancer, promotes affordable detection and treatment, advocates beneficial legislation and regulation, and serves as a national voice for the rights and concerns of breast cancer patients. NABCO has 300 organizational members.

### US TOO

US TOO is an independent national organization founded in 1990 to provide support for prostate cancer survivors and their families. Through grants made to the American Foundation for Urologic Disease, US TOO has helped start more than 140 US TOO local support groups in 39 states and 3 foreign countries.

### Y-ME National Organization for Breast Cancer Information and Support, Inc. (Y-ME)

Y-ME is a nonprofit consumer-oriented organization that provides information, referral, and support to individuals concerned about or diagnosed with breast cancer. Its national toll-free Hotline is staffed by trained counselors and volunteers who have experienced breast cancer. Y-ME and its chapters nationwide conduct community educational programs and support groups. Y-ME publishes a bimonthly award-winning newsletter and provides written materials on all aspects of breast disease.



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**CancerCare, Inc.®**

April 16, 1993

The Honorable Fortney H. Stark  
Chairman, Subcommittee on Health  
House Ways & Means Committee  
1114 Longworth  
Washington, DC 20515

Dear Congressman Stark:

As one of the member groups of the Cancer Leadership Council on Health Care Reform, Cancer Care greatly appreciates this opportunity for the Council's Statement on Health Care Reform to be considered in discussion of uniform benefit requirements.

Each of the groups supporting the statement serves the community of cancer patients and their families in an important and individual way. Cancer Care has been providing professional, comprehensive social services to patients and families at no cost to the client for nearly 50 years. Given that breadth of experience, Cancer Care is able to speak out with real authority on issues of concern to people coping with cancer. Following are facts illustrating some basic realities for our clients.

-- Over 50% of all cancer patients are treated with drugs which, by some standards, are considered experimental and therefore not covered by third party payers. Amid a fierce debate over exclusion clauses in insurance policies for experimental treatment, quality of care is compromised and patients often must choose between suing their insurers or indebting themselves for life to a hospital billing department.<sup>1</sup>

-- The care of a cancer patient today may necessitate diagnostic testing, state-of-the-art therapy, mental health services, prescription drugs, rehabilitation, prostheses, home care, hospice, nutritional supports and more. A "basic package of benefits" that fails to cover these essential needs will leave the nation's 8 million cancer survivors severely underinsured.<sup>2</sup>

Until the cure, we offer the care.

April 16, 1993

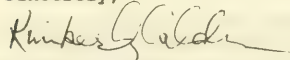
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- The best diagnosis, treatment and ongoing care of people with cancer is critically linked to access to appropriately trained clinicians and the treatment they recommend. Cost containment measures that attempt to circumvent or substitute that level of expertise and care could compromise the future prognosis of cancer survivors.

These issues of critical import to cancer survivors are addressed by the statement which articulates essential components for health care reform for our community. We urge you to note the statement's significance as a collaborative and unbiased effort of people living with cancer and their supporters.

On behalf of the 35,000 individuals who receive direct assistance from Cancer Care each year, and for those three out of four immediate families who will battle cancer at some point, we urge you to advocate for the crucial needs of people with cancer throughout the debate on health care reform.

Sincerely,



Kimberly Calder, MPS  
Director of Public Policy

1. U.S. General Accounting Office Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, "Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies", September 1991

2. Arthur Holleb, MD, Diane Fink, MD, Gerald Murphy, MD, editors; American Cancer Society Textbook of Clinical Oncology, 1991



### National Health Care Reform

The Susan G. Komen Breast Cancer Foundation, Inc. believes that National Health Care Reform must provide all individuals access to the basic elements of breast health, including prevention, screening diagnosis, medically appropriate treatment, physical and emotional rehabilitation, long-term follow-up, and palliative care.

Health care reform development must include special efforts to address the needs of minorities and the medically underserved to overcome geographic, economic and cultural barriers to health care. Community-based programs for screening, diagnosis, and treatment must be expanded to increase significantly their accessibility to the underserved and traditionally disadvantaged populations.

The Komen Foundation has presented its "Essential Elements For Health Care Reform For Breast Cancer" and background on the Foundation to the Chairman of the Health Reform Task Force and First Lady, Hillary Clinton, as well as to the Members of Congress.

\* \* \* \*

The Susan G. Komen Breast Cancer Foundation is a Texas 501 (c)3 organization founded in 1982 by Nancy Brinker in memory of her sister, Susan G. Komen, who died of breast cancer at the age of 36. Its mission is to eradicate breast cancer as a life threatening disease by advancing research, education, screening and treatment.

According to the National Cancer Institute (NCI), 182,000 American women will be diagnosed with breast cancer this year; 46,000 will die. Educating women to practice early detection is our best defense in saving lives. The mortality rate would fall by 30% if women within the recommended guidelines for a mammogram received one.

The Komen Foundation actively works at national, state and local levels to increase support for breast cancer research, education, screening and treatment, especially for the medically underserved. The Foundation's leaders are national advocates on breast cancer issues. Founder Nancy Brinker serves on the President's Cancer Panel and chairs the President's Special Commission on Breast Cancer. Komen representatives have testified and worked with other cancer groups in support of substantial increases in federal funds for breast cancer research, achieving a total of \$406 million for FY 1993 (or \$236 million in new funds). The Foundation also played a major role in the enactment of the Mammography Quality Standards Act of 1992.

The Foundation operates a national helpline (1-800-I'M AWARE) using trained volunteers to assist callers with breast cancer concerns. Since 1989, The Komen Foundation has sponsored, with NCI, The Leadership Summits on Breast Cancer to increase and promote public/private partnerships that encourage community-based and regional programs for awareness, screening, and treatment of breast cancer. Komen participates in other cooperative ventures and sponsors symposia with the National Institutes of Health, American Cancer Society, Centers for Disease Control and cancer advocacy groups.

The Susan G. Komen Breast Cancer Foundation

*National Headquarters:*

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Komen Help Line: 1-800-I'M AWARE (1-800-462-4233)

FAX: (214) 450-1770



Mr. ANDREWS. Thank you for your testimony.

Our next witness is Dr. Keith Hoots from Houston. I am glad to see you here. Welcome.

**STATEMENT OF W. KEITH HOOTS, M.D., ASSOCIATE PROFESSOR OF PEDIATRICS AND INTERNAL MEDICINE, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER, HOUSTON, TEX., AND DIRECTOR, GULF STATES HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTER, ON BEHALF OF THE NATIONAL HEMOPHILIA FOUNDATION**

Dr. HOOTS. Thank you, Mr. Chairman. I am Keith Hoots from the University of Texas M.D. Anderson Cancer Center and Health Science Center, and I am the regional medical director for the hemophilia treatment center that provides services to the four-State area of Texas, Oklahoma, Arkansas, and Louisiana. Today I represent the National Hemophilia Foundation, and I wish to make several key points as they relate to the care of chronic disease under any new plan for health care in this country.

In the first panel this morning, there was quite a bit of discussion about the role preventive care plays in cost-savings. One of the things we have learned in comprehensive hemophilia treatment centers over the last decade and a half is that with chronic disease particularly, as well as with healthy adults and children, by managing the disease specifically and by having specialists who are able to take on that mandate, one can reduce the costs of medical care over the long term. Congress recognized this in 1976 when they created the comprehensive hemophilia treatment centers.

At the end of my testimony, there is a table which shows the 10-year impact on both actual dollar costs as well as costs in terms of morbidity, time lost from work and school, et cetera. I think it makes the case strongly that if you have a well-targeted medical approach, if it is tied closely to individual needs, if it provides a comprehensive system that deals with not only the acute medical problem, but the management of the morbidity in a disease like hemophilia, that it does save money.

Hemophilia, as you know, in the traditional sense led to crippling disease because of bleeding in the joints. The efforts of comprehensive care and the onset of therapy with factor concentrates resulted in an increased survival from hemophilia from 1960 to 1980 of 43 to 63 years. Unfortunately, this was a double-edged sword, as you know. Because of the impact of contaminated factor concentrates, a large proportion of this population alive at that time was infected with HIV.

Under our mandate as a comprehensive treatment center, we then took on HIV care, and the specialists that have evolved have taken on this with a vigilance that certainly, if anything, surpassed that which we had seen before.

It makes the point that if you have committed professionals, you give them the opportunity to devise the program, and they work closely with lay sponsoring organizations like the National Hemophilia Foundation, a strong effort can be made to reduce morbidity, reduce costs, and decrease mortality.

Finally, I want to make two other ending points. One is that hemophilia is a very costly disease, as you are aware. Because of the

efforts of people on this subcommittee and in Congress, modifications were made to Medicare's diagnosis-related group reimbursement to provide an additional payment for factor concentrate in inpatient settings. That was important. One of the reasons it was important is because only selected, very specialized hospitals provide this sort of chronic care and they take on an inherent burden by doing so. If the anticipated health care plan doesn't take this into account, then there is a disincentive for those hospitals to take on these expensive patients.

In the context of a managed competition system, this is very important because of the needed link between the primary and secondary providers in managed care allowing for comprehensive chronic care delivery so that this transition can be made and there is no disincentive for treating patients with chronic disease.

Thank you very much.

[The prepared statement and attachment follow:]

STATEMENT OF THE  
NATIONAL HEMOPHILIA FOUNDATION  
TO THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
UNITED STATES HOUSE OF REPRESENTATIVES

ON THE  
HEALTH BENEFIT STRUCTURE UNDER HEALTH  
CARE REFORM LEGISLATION

PRESENTED BY  
W. KEITH HOOTS, M.D.

APRIL 22, 1993

Mr. Chairman and members of the Subcommittee, I am Dr. Keith Hoots, Associate Professor of Pediatrics and Internal Medicine at the University of Texas Health Science Center in Houston, Associate Professor of Pediatrics and Section Head Pediatric Hematology, University of Texas - M.D. Anderson Cancer Center, and the Director of the Gulf States Hemophilia Diagnostic and Treatment Center which is a regional coordinating center for people with hemophilia in the states of Texas, Oklahoma, Louisiana and Arkansas. Today I am representing the National Hemophilia Foundation, a voluntary health agency working to improve the health and welfare of the 20,000 persons with hemophilia, von Willebrand disease and other clotting factor deficiencies in the U.S.

Hemophilia is a lifelong, hereditary blood clotting disorder which affects males almost exclusively. The blood of a person with hemophilia does not clot due to the inactivity of a plasma protein. Without proper treatment, a person with hemophilia may experience uncontrolled, painful bleeding and/or chronic joint bleeding, resulting in progressive joint damage and serious disability. Since 1965, the development of clotting factor concentrates has allowed most persons with hemophilia to manage their bleeding episodes at home, eliminating the need for frequent and costly hospitalization and ensuring that even persons with severe hemophilia are able to attend school, obtain full time employment and lead productive lives.

But this medical miracle has had a double edge to it. Prior to 1985, the blood components derived from hundreds of thousands of donors were neither heat-treated nor donor-screened. As a result, 80% of persons with severe hemophilia and 60% of the overall hemophilia population has become HIV-infected. About 12% of spouses/sexual partners of persons with hemophilia have been exposed to HIV, which has had a profound impact on families affected by hemophilia.

I would like to direct my testimony to the unique health care needs of individuals living with hemophilia and HIV/AIDS and the importance of preserving the comprehensive health care services currently provided by the network of hemophilia diagnostic and treatment centers in any reform of the health care system. For people living with a chronic disease like hemophilia, access to basic services such as inpatient hospital and outpatient physician care and drug therapy is not the same as for providing care for your average healthy American. Physicians caring for people with hemophilia are specialists in hematology and many have developed specialized knowledge of HIV disease and have become experienced in both comprehensive hemophilia and HIV/AIDS treatment services. Hospitals best equipped to care for these patients are most often academic or tertiary health care centers where most hemophilia treatment centers are located and specialists in an array of services can be found. Drug costs are astronomical for the hemophilia community -- an average healthy person with severe hemophilia can spend over \$60,000-\$100,000 a



year on clotting factor alone and another \$10,000 a year for HIV drug treatment.

Clearly people with hemophilia would be greatly assisted and relieved of significant financial pressures and anxiety if a health care reform plan were enacted. NHF supports Congressional and Administration efforts to reform the existing health care system and establish a national health policy based on universal access, portability of coverage and no limitations or differentials in payment due to preexisting conditions. At the same time, we are concerned that in the rush to reform, legislation not be adopted that inadvertently creates disincentives to ensure direct access to the specialized comprehensive services that are most needed and medically effective for people with hemophilia.

The National Hemophilia Foundation recommends that the standard benefit package mandated under health care reform allow for the specialized benefits needed by people with hemophilia. Legislation must provide for:

1. coverage of specialized comprehensive care provided through the regionalized network of hemophilia treatment centers as well as direct access to infectious disease specialists for the treatment of HIV and AIDS,
2. full coverage for the safest and most effective clotting factor and HIV drug products, and
3. the availability of home health care, prevention and patient education services.

It is imperative that legislators fully understand the magnitude of the health care problems confronted by people with hemophilia and their families. The onset of HIV disease in the hemophilia population has had a profound long term effect in terms of survival. What you may not know, however is that from the period from 1960 to 1980 - - before the onset of HIV - - the expected lifespan of a person with hemophilia had increased dramatically from 43 to 63 years because of at least two critical developments: One is the development of the factor concentrates that allowed for early and aggressive treatment of the bleeding disorder. The second was the Congressional authorization providing for the development of the Network of Comprehensive Hemophilia Care Centers funded through the Maternal and Child Health Program.

Through legislation passed by Congress in 1975, geographically dispersed or regional centers were established that have evolved into a network of nearly 150 facilities caring for about two thirds of the hemophilia population. The comprehensive care model is built on a family-centered, multi-disciplinary care team approach that addresses the individual medical, psychosocial, dental and other health care needs specific to this rare and very costly disease.

The core comprehensive services provided by the hemophilia treatment centers include:

- o a coagulation laboratory of recognized high standards;
- o a blood bank providing all of the blood components need by patients with hemophilia;
- o a multidisciplinary hemophilia care team including a hematologist, internist, pediatrician, orthopedic surgeon, physical therapist, dentist, social worker and registered nurse;

- o formal linkages with mental health, genetic counseling and rehabilitative services;
- o a training course in self therapy (how to self-infuse clotting factor) and updated hemophilia concepts for patients and families;
- o an outreach program to enable every person with hemophilia within the area to receive the services of the center.

The results of utilizing this model of care that emphasizes comprehensive early intervention and home care have been extremely positive and prior to the onset of HIV cost effective. Data collected in 1985 as compared to similar data from 1975, the year before the program began, show more than a 300% increase in the number of patients receiving comprehensive care for hemophilia and nearly a 400% increase in the number of patients on self-infusion (transfusing themselves with clotting factor in their own home). These increases in participation in comprehensive care resulted in a 73% decrease in the average number of days per year lost from work and school and an 88% reduction in the average number of hospital admissions per year, including a reduction in the average length of stay per admission of about eight days. Attached to my testimony is a chart that will provide the Subcommittee with this remarkable outcome data.

Even with the onset of HIV and AIDS in the hemophilia population, we had a comprehensive care system in place which enabled patients to have access to state-of-the-art AIDS treatment more readily. With support from NIH, utilizing the existing network of care, NHF has established an innovative "AIDS clinical Trial Unit (ACTU) without walls" that allows many of the hemophilia treatment centers to participate in AIDS Clinical Trials. For those that do not participate in this network, efforts are made to provide individuals with hemophilia who are HIV positive with access to infectious disease specialists and therapies. In addition, the comprehensive care system was there to provide many of the psychosocial and AIDS risk reduction, self-help and family support services needed by this population, now forced to deal with two chronic diseases.

Having described the benefits of comprehensive care, NHF is greatly concerned that direct access to these centers be maintained under a health care reform plan. In my experience with existing managed care plans, often in an effort to hold down costs, plans will insist that their "inhouse specialist" provide hemophilia care rather than refer their patients to the treatment center in the area. As you can imagine with only 20,000 people in the U.S. with hemophilia there are not many health care professionals with expertise and experience in caring for this disease. Unless a hematologist went to a medical school where a hemophilia treatment center is located it is likely that the physician has never been trained in providing chronic care for a patient with hemophilia. So what frequently occurs in the effort to manage costs is substantially less care than the specialized preventive care required for joint bleeding and other morbidities. The end result is higher long term costs. For many of the HMOs in my area, we have managed to convince them of the cost effectiveness of the comprehensive care provided by the hemophilia treatment center, but it has required extensive protracted negotiations that have resulted in delays in adequate care for patients.

In light of these facts, NHF recommends that the health care reform plan recognize the comprehensive hemophilia diagnostic and treatment centers as "essential community providers" (or whatever the appropriate term may be) for the hemophilia community.

Now, within the spectrum of comprehensive care, the essential benefit for people with hemophilia is coverage of and full

reimbursement for clotting factor and for HIV/AIDS drugs. Clotting factor alone can cost a person with severe hemophilia anywhere from \$50,000 to over \$100,000 a year. If surgery is needed, this figure could double. The Subcommittee is well aware of this problem as it voted to establish and extend an additional payment for clotting factor under the Medicare DRG payment system. Medicare data showed that in many hemophilia hospital admissions the cost of clotting factor alone was as great or greater than the entire DRG payment. I am hopeful that an extension of this provision will be included in your soon to be considered Medicare reconciliation package.

Due to the exorbitant cost and the necessity by the hemophilia population, it is essential that drug coverage be included in the standardized benefit package. It is also important with regard to treating hemophilia that the physician be able to determine what kind of factor concentrate to prescribe and not to be limited by a formulary or other cost constraints. Prices for clotting factor vary, quite often based on the purity of the product. While all products on the market today are virally safe for HIV, some allow for the transmission of hepatitis. Therefore, it is critical that the flexibility exists under a new system to prescribe the most effective drug for the patient.

The other essential benefits that should be included in a standard benefit package under health care reform are: coverage for home care, prevention and education services. For the hemophilia community these three services are tightly integrated. Through comprehensive treatment patients with hemophilia are educated and trained to determine when they, or in the case of parents how to identify when their child is having a bleed, and then how to administer clotting factor in the home. This immediate attention to a bleeding joint has had an incredible preventive effect resulting in fewer crippling side effects as well as reducing the need for surgery which is both risky and costly. In today's hemophilia community over 90% of patients receive their clotting factor at home and either self-infuse or have a family member assist them. Only through the educational services provided by the hemophilia treatment centers could patients and families receive this cost effective, preventative care.

Finally, the Subcommittee should also give consideration to the need for catastrophic benefits or contingencies in any new health care system. Hemophilia is a paradigm of such needs. It is an expensive chronic disorder, even if you are healthy, so the costs of a complicated or very ill patient can be astronomical. I had three patients that incurred hospital costs in excess of \$600,000 for which the hospital was reimbursed only \$16,000 and that included the outlier payments. It is extremely important that consideration be given to diseases like hemophilia in which morbid events must be covered without undue financial risk to the specialized institutions that provide this care. It is likely under the new system that the financial risks for caring for expensive diseases like hemophilia will not be spread evenly across hospitals or health plans. Some mechanism must be established so that the disincentives to care for costly patients are minimized.

In summary, diseases like hemophilia that require frequent medical supervision, intense and expensive intervention therapy, and long-term preventive care demand special consideration under any national healthcare delivery plan. The comprehensive treatment model as pioneered by the hemophilia treatment centers and adopted by a number of other chronic diseases can serve as a blueprint for rare and medically intensive chronic diseases in which multidisciplinary medical expertise is required.



## NEW TREATMENT CENTER DATA REVEAL "REMARKABLE" HEALTH AND ECONOMIC OUTCOMES

### OUTCOME DATA FROM 31 DMCH FUNDED COMPREHENSIVE HEMOPHILIA CENTERS AND THEIR AFFILIATES

Outcome Data	Year Before Program (1975)	Tenth Year of Program (1985)	Percent Increased Percent Decreased (-)
No. patients seen at primary centers	1,783	5,606	+214%
No. patients seen at affiliate centers	329	1,641	+399%
No. patients receiving regular comprehen- sive care	1,333	5,683	+326%
No. patients on self- infusion ("home care")	514	2,517	+390%
Average days/year lost from work or school	14.5	3.9	-73%
Average hospital admission/year	1.9	0.22	-88%
Average days/year spent as inpatient	9.4	1.6	-83%
Percent patients with third party coverage	74	93	+26%
Out-of-pocket expense/ patient/year	\$ 1,700*	\$ 396.	-77%
Overall costs of care/ patient/year	\$31,600*	\$8,127.	-74%
Percent unemployed adults	36	9.4	-74%

\*adjusted for 1985 dollars

Mr. ANDREWS. Thank you very much, Dr. Hoots.  
Mr. Wilson.

**STATEMENT OF PHILL WILSON, MEMBER, BOARD OF DIRECTORS, AIDS ACTION COUNCIL, DIRECTOR OF PUBLIC POLICY, AIDS PROJECT LOS ANGELES**

Mr. WILSON. Good morning, Mr. Chairman. My name is Phill Wilson. I am the director of public policy at AIDS Project Los Angeles. I am here today representing the AIDS Action Council. I serve on the board of directors and the public policy committee of the council. But, more importantly, I am a consumer. I am here today as a person who has lived with HIV disease for 13 years.

On January 1, 1993, I became a person with AIDS as a result of the new AIDS definition. I am here today to speak to you about the criteria against which the HIV/AIDS community will measure the various proposals for health care reform and the basic benefits that are critical to treating this disease.

HIV and AIDS poses many of the same challenges to the health care system as any chronic disabling condition. The reformed health care system must be able to meet the needs of all Americans—and all Americans are at risk of developing life-threatening, chronic disabilities, including HIV infection.

The extent to which any plan, offered by the administration or Congress, addresses the need of individuals with HIV infection will serve as one important indicator of that plan's responsiveness to the mandate of the people.

A comprehensive standard health benefit package must be the cornerstone of any national health care reform proposal. Given the multiple and changing medical interventions necessary to successfully manage HIV infection, access to comprehensive and high-quality service is vital.

As an advocate and spokesperson for a national organization committed to all persons with HIV disease, as a policymaker for HIV disease over 10 years, and as a person personally living with the disease, we support a benefit package which responds to a broad range of needs and populations by including benefits for AIDS-related pediatric services, obstetrical and gynecological care, substance abuse treatment and mental health services. Because of the many opportunistic infections to which persons with HIV are vulnerable, we are concerned that diagnostic testing, preventive vaccines, vision, and dental care be covered services.

Because of their special importance to persons with HIV, I would like to offer additional information about several health care services we see as integral to any standard benefits package.

To begin with, prescription drug coverage. Any basic benefit package should allow a physician the flexibility to prescribe the most appropriate treatment for the HIV/AIDS patient, which may include FDA-approved, off-label, and experimental therapies. In a life or death situation, experimental therapies may be the only line of defense. Comprehensive and flexible coverage for pharmaceutical drugs is a health care imperative for people living with HIV disease.

Substance abuse treatment and mental health services: A standard benefits package must provide a comprehensive continuum of

care to treat drug addiction, alcoholism, and mental health illnesses. Traditionally, mental health services have been significantly circumscribed and, along with substance abuse treatment, subject to higher deductibles than other health care services, with stringent lifetime caps. A national standard benefits package must be responsive to all the needs of the individual and should not present financial or service barriers for psychological and addiction treatment.

The needs of the HIV/AIDS-infected person represent the full continuum of health care services. A case manager, with HIV experience, fills an advocacy and coordinating role to interface with the myriad of health and social service systems to help the patient access the most timely and appropriate services.

Early intervention care prevents further suppression of the immune system and the opportunistic infections associated with immunosuppression. Early intervention makes good fiscal sense for HIV, as with virtually every other medical condition.

I have lived with this disease for 13 years. I work every day. I pay taxes every day. I am able to do that because I had access to early intervention.

As the disease progresses, hospitalization may become more frequent, and the AIDS patient's health care plan's options must provide for skilled nursing care, home- and community-based care, and hospice services.

There is no doubt that a comprehensive standard health benefit is essential if national health care reform is to meet the needs of people with HIV and AIDS. But many other components of the reform plan will affect whether or not individuals with HIV can access the services outlined in the benefit. Freedom to choose your own health care providers, payment for coverage based on ability to pay, confidentiality protections, and universality and uniformity of coverage are just some of the other essential principles of health care reform by which the AIDS community will address any health care issue.

The need for national health care reform based on these principles I have outlined is urgent. Right now people with AIDS and HIV disease do not receive the care they need for the very reasons our health care system needs reform. Many health care providers, both physicians and allied health professionals, are not trained in identifying or treating HIV disease.

National health care reform must eliminate these practices. We must now invest the time and resources to provide a continuum of health care services that will allow for well-being and peace of mind. We, like all Americans, have been waiting too long to access a fundamental human right—guaranteed, high-quality, comprehensive, affordable health care. We look to your leadership to make that right a reality during this session of Congress.

I will be more than happy to answer any questions you may have.

[The prepared statement follows:]



## TESTIMONY OF PHIL WILSON AIDS Action Council

Good morning. I am Phill Wilson, director of public policy at AIDS Project Los Angeles (APLA). I am here today representing the AIDS Action Council, the national organization which serves as the Washington representative of over 900 community-based AIDS service providers including APLA. I serve on the Board of Directors and Public Policy Committee of the Council. I am also here today as a man who has lived with HIV for thirteen years.

I have recently been diagnosed with AIDS as a result of the new AIDS definition. During the time I have been HIV-infected, I have remained relatively healthy. I do have health insurance through my employer. Through my current coverage, I can access some of the services that are essential to care for a person with HIV infection. However, my health plan is a managed care system and I experience long waiting periods for an outpatient visit. Fortunately, I have friends who are physicians with HIV expertise. Without them, I would not have remained healthy for so long. In fact, I must rely on physician friends outside of my managed care plan to provide ninety percent of my care.

I am here today to speak to you about the criteria against which the HIV/AIDS community will measure the various proposals for health care reform and the basic benefits that are critical to treating this disease. HIV/AIDS poses many of the same challenges to the health care system as any chronic disabling condition. The reformed health care system must be able to meet the needs of all Americans--and all Americans are at risk of developing life-threatening, chronic disabilities, including HIV infection. The American people are committed to the adoption of a national health care reform program which will cover and be responsive to all of our people, at all stages of their lives, regardless of disability status. The extent to which any plan, offered by the Administration or Congress, addresses the needs of individuals with HIV infection will serve as one important indicator of that plan's responsiveness to the mandate of the people.

A comprehensive standard health benefit package must be the cornerstone of any national health care reform proposal. Given the multiple and changing medical interventions necessary to successfully manage HIV infection, access to comprehensive and high quality services is vital. As an advocate and spokesperson for a national organization committed to all persons with HIV, we support a benefit package which responds to a broad range of needs and populations by including benefits for AIDS-related pediatric services, obstetrical and gynecological care, substance abuse treatment and mental health services. Because of the many opportunistic infections to which persons with HIV infection are vulnerable, we are concerned that diagnostic testing, preventive vaccines, vision and dental care be covered services.

A growing number of people with HIV/AIDS now rely on alternative therapies to prevent or relieve symptoms. Faced with a limited number of traditional medical treatments, they have looked to massage, acupuncture, herbal healing and nutrition to ameliorate their pain and halt HIV proliferation. A study is currently being conducted at the National Institutes of Health that examines the effects of acupuncture in relieving the pain of the chronically ill. Depending on the results of this study, an effective nontraditional therapy would offer an alternative to expensive drug therapy. A comprehensive standard benefit should offer flexibility which can provide alternative treatments especially with diagnoses like HIV/AIDS with its evolving standards of care.

Because of their special importance to persons with HIV, I would like to offer additional information about several health care services we see as integral to any standard benefit package.

### Prescription Drug Coverage

Any basic benefit package should allow a physician the flexibility to prescribe the most appropriate treatment for the HIV/AIDS patient, which may include FDA-approved, off-label and experimental therapies. Coverage should also be provided for multi-level treatments such as antiviral treatment, opportunistic infection prophylaxis and anti-anemia medications. In a life or death situation, experimental therapies may be the only line of defense. Although expensive and controversial, experimental therapies should be covered on a case-by-case basis. Today, the high cost of many of these therapies impoverish middle-class individuals and are simply unavailable to the poor without major federal and state subsidies through Medicaid and Ryan White funds. Comprehensive and flexible coverage for pharmaceutical drugs is a health care imperative for people with HIV/AIDS.

## Substance Abuse Treatment and Mental Health Services

A standard benefit package must provide a comprehensive continuum of care to treat drug addiction and alcoholism. The Centers for Disease Control and Prevention currently estimates that at least 32 percent of the current AIDS cases have occurred directly and indirectly from intravenous drug use. Among women, the figure is 71%. Moreover, drug and alcohol intoxication have been associated with high risk behavior such as unprotected sex. Treating drug addiction is a key HIV prevention strategy. Providing drug treatment to those already infected with HIV empowers them to take control over their lives and their health. Universal access to drug treatment in a national health care plan will also reduce perinatal transmission of HIV and the devastating toll of this illness on entire families.

Once a person is diagnosed with HIV, a counseling referral should be provided immediately. Fear of losing employment, the support of family and friends and above all, the prospect of premature death can cause significant stress. Access to mental health services offers vital psychological supports. Traditionally, mental health services have been significantly circumscribed, and along with substance abuse treatment, subject to higher deductibles than other health care services with stringent lifetime caps. A national standard benefit package must be responsive to all of the needs of an individual and should not present financial or service barriers for psychological and addiction treatment.

## Living with an AIDS Diagnosis

The needs of the HIV/AIDS infected person represent the full continuum of health care services. A case manager, with HIV/AIDS expertise, fills an advocacy and coordinating role to interface with the myriad of health and social service systems to help the patient access the most timely and appropriate services.

Early intervention care prevents further suppression of the immune system and the opportunistic infections associated with immunosuppression. Early intervention makes good fiscal sense for HIV, as with virtually every other medical condition. Access to a range of primary health care services, both inpatient and outpatient, are critical.

As the disease progresses, hospitalizations may become more frequent and the AIDS patient's health care plan's options should provide for skilled nursing care, home and community-based care and hospice services.

There is no doubt that a comprehensive standard health benefit is essential if national health care reform is to meet the needs of people with HIV/AIDS. But many other components of the reform plan will affect whether or not individuals with HIV can access the services outlined in the benefit. Freedom to choose our own health care providers, payment for coverage based on ability to pay, confidentiality protections, and universality and uniformity of coverage are just several of the other essential principles of health care reform by which the AIDS community will measure any health care reform package.

I have attached a copy of the AIDS Action Council's Health Care Reform Statement of Principles to my testimony to be submitted for the hearing record.

The need for national health care reform based on the principles I have outlined is urgent. Right now people with HIV/AIDS do not receive the care they need for the very reasons our health care system needs reform. Many health care providers, both physicians and allied health professionals are not trained in identifying or treating HIV disease. Primary care and specialty physicians are not available in urban and rural areas. Physicians and hospitals refuse to treat HIV patients because they are at a direct financial disincentive to provide care to AIDS patients or they ignorantly fear the risk of HIV transmission. Insurance companies cap disease-specific coverage. Over the last decade, thousands of people with HIV have died because the necessary preventive care was not accessible or affordable. Thousands more have contracted the HIV virus because of the failure of our health care system to provide adequate drug treatment services.

Countless individuals with HIV/AIDS have been denied compassionate care because of a system which allows institutional discrimination against us.

National health care reform must eliminate these practices. We must now invest the time and resources to provide a continuum of health care services that will allow for well-being and peace of mind. We, like all Americans have been waiting too long to access a fundamental human right--guaranteed, high quality, comprehensive, affordable health care. We look to your leadership to make that right a reality during this session of Congress.

## **Health Care Reform Statement of Principles**

The following are the criteria against which the HIV/AIDS community will measure the various proposals for health care reform. HIV/AIDS poses the same challenges to the health care system as any chronic disabling condition. The reformed health care system must be able to meet the needs of all Americans -- and all Americans are at risk of becoming disabled, whether the cause of their disability is HIV, Alzheimer's, stroke, multiple sclerosis, or any other condition. To be acceptable, any proposed administrative structure must meet all of the following criteria:

### **UNIVERSAL COVERAGE**

Coverage should be universal and uniform. All U.S. residents should be covered by the health plan and receive the same set of benefits. Whether or not coverage and benefits are tied to employment; the method for accessing health care and the scope of benefits should be the same regardless of employment status.

### **COMPREHENSIVE COVERAGE**

All medically necessary health care should be part of any benefits package, including coverage for in-patient and out-patient primary health care services, including full gynecological services, preventive health services such as prenatal and well-baby care, prescription drugs (including off-label use of approved drugs and ancillary and actual costs of experimental treatments), hospice care, long- and short-term home and community-based services, substance abuse treatment, mental health services, outpatient rehabilitation services, dental care, vision care, and the healing arts. Case management should be provided to link people with appropriate health and social services.

### **FREEDOM OF CHOICE**

Individuals should be free to choose their own health care provider. Individuals should not be required to join a plan or delivery system if the individual does not believe that program will meet his or her needs. In addition, individuals should be allowed to change providers if they are not satisfied with the care provided. This is particularly important for people with HIV infection, given that a relatively small number of physicians are experienced in treating people with HIV and there is no credentialing process that identifies those qualified or experienced with HIV disease.

### **NO FINANCIAL BARRIERS TO CARE**

Payment for coverage should be based on ability to pay, not based on a flat premium schedule. Out-of-pocket payments should also be based on income. If there is a system of copayments or deductibles, it should be designed so as to prevent sick people from being disproportionately burdened. (For example, if copayments are based on a per visit or a per prescription basis, sick people will pay a larger portion of their income for health care coverage.)

### **GOVERNMENT RESPONSIBILITY**

The federal government must exercise its authority to assure that health care is delivered equitably and cost effectively through the following:

- Global budgeting, which sets targets for health care spending by sector and is the most effective way of assuring appropriate distribution of scarce health care resources while reining in inflation in the health care field.
- Undertaking initiatives to redistribute the availability of health care (especially health care practitioners) to underserved areas and populations, including appropriate education and financial incentives to increase the number of primary care providers.
- Guaranteeing the involvement of consumers in all aspects of decisionmaking associated with any new health care system.
- Guaranteeing the confidentiality of all aspects of patient involvement with the health care system.



- Achieving quality assurance through establishment of federal standards of care and minimum standards for quality assurance methods.
- Requiring nondiscrimination in accessing the health care insurance system, whether demographic or based on preexisting medical conditions.
- Assuring that appropriate care is given to all Americans, meaning that the appropriate services are given for the appropriate level of need.
- The government must assure access to care under existing mechanisms *during a transition to the new health care system*.
- The government must not "de-institutionalize" the traditional public health programs even after a new system of health care delivery is established.
- The government must assure full disclosure to and appropriate education of all participants regarding access and options within the new system.

Mr. ANDREWS. Thank you, Mr. Wilson.  
Dr. Francis.

**STATEMENT OF CHARLES FRANCIS, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN HEART ASSOCIATION, AND PROFESSOR OF CLINICAL MEDICINE, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, AND CHAIRMAN, DEPARTMENT OF MEDICINE, HARLEM HOSPITAL CENTER, NEW YORK, N.Y.**

Dr. FRANCIS. Thank you, Mr. Chairman.

I am Dr. Charles Francis. I am a professor of clinical medicine at the College of Physicians and Surgeons of Columbia University, and chairman of the Department of Medicine at the Harlem Hospital Center in New York City. I am here today on behalf of the American Heart Association, and I am a member of the American Heart Association board of directors.

Since heart disease and stroke remain the number one killers in the country, health care reform is the top priority for the American Heart Association. I have provided you with a copy of the principles of access to health care that we believe should be the basis for health care reform.

We have also developed a package of basic preventive cardiovascular services that should be a part of basic medical coverage. The benefit package that is attached to my testimony is awaiting final AHA approval, but it reflects accepted procedures and principles for the prevention of cardiovascular diseases.

In the past three decades, great strides have been made in the diagnosis and treatment of heart disease with a resulting decline in cardiovascular deaths. Much of this improvement may also be attributed to changes in life-style. All Americans should pay much more attention to modifiable risk factors such as high total cholesterol levels in the blood, cigarette smoking, hypertension, physical inactivity, obesity, and elevated blood sugar.

Implementation of preventive measures can have a major impact on the health of individuals as well as the general public.

The American Heart Association believes that a basic medical care plan should include the following cardiovascular preventives services: blood pressure checks, cholesterol screenings, electrocardiograms, exercise stress testing, counseling, and medications. We don't believe that every procedure should be available on demand. The attached document provides detailed recommendations for when and for whom these procedures should be done.

I would also like to stress the importance of counseling at the primary care level. This is particularly true for populations most likely to develop heart disease and stroke, such as African Americans, persons with low incomes, persons with high normal blood pressure, those with a family history of hypertension, and individuals with one or more life-style risk factors for cardiovascular disease.

Periodic counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium, and caloric balance, as well as the need for a regular exercise program are critical. For those people who are at high risk with high cholesterol levels, we recommend that diet therapy, with monitoring and long-term followup

by a physician, registered dietician, or licensed nutritionist, be covered under the health plan.

Providing coverage for counseling on prevention and cessation of tobacco use is also very important to the American Heart Association. Tobacco use is the number one preventable cause of death in the United States, and we know that most smokers would like to quit, but can't. We also know that smoking cessation programs work and that they are cost-effective.

However, AHA believes that only proven and effective programs conducted by appropriate and qualified individuals should be covered. In fact, the Agency for Health Care Policy and Research is going to develop practice guidelines on smoking cessation and prevention. We are presented with a great opportunity at this point in time to provide the encouragement to quit that smokers need. That, coupled with increased excise taxes and FDA regulations on tobacco products, would have a tremendous impact on decreasing tobacco use in this country.

Mr. Chairman, prevention as part of routine medical care and as part of public and professional education programs should be included in the health care reform program. The American Heart Association has public education programs to inform people how to reduce their risk of heart disease. These efforts will be greatly complemented by a comprehensive health care plan, accessible to all, that includes prevention, preventive programs, and cardiovascular health care as outlined in the attached document.

We thank you for your time and consideration.

[The prepared statement follows:]



**TESTIMONY OF CHARLES FRANCIS, M.D.  
American Heart Association**

On behalf of the American Heart Association, I would like to thank the subcommittee for affording me the opportunity to be here today. I am Dr. Charles Francis, a member of the AHA Board of Directors and Professor of Clinical Medicine at the College of Physicians and Surgeons of Columbia University and Chairman of the Department of Medicine at the Harlem Hospital Center in New York City.

The American Heart Association is a non-profit, voluntary health organization funded by private contributions. The goal of the association is to reduce disability and death from cardiovascular diseases and stroke. To support this goal the AHA has contributed more than one billion dollars to cardiovascular research since 1949. Over the years AHA funded research has yielded many important discoveries such as CPR, life-extending drugs, bypass surgery and other surgical techniques. The AHA's educational programs are designed to promote healthy habits as well as prevent and reduce the risk of heart disease and stroke.

With heart disease and stroke continuing to be the number one killers in the country, naturally health care reform is a top priority for the American Heart Association. Thousands of lives could be saved each year if we had a comprehensive, universal health plan that met the health care needs of all U.S. residents. A solid foundation for health care reform, which is detailed in the attached Access to Health Care Principles document, includes universal access, coverage for basic medical care, preventive care, biomedical and clinical research, and practice guidelines and quality, outcomes, cost-effectiveness research. The AHA recommends that these principles be included in any health care reform proposal that is enacted.

We have also developed a package of basic preventive cardiovascular services that should be a part of basic medical coverage. The benefit package that is attached to my testimony is awaiting final AHA approval, but it reflects accepted procedures and principles for the prevention of cardiovascular diseases. Some modifications could be made as a result of changes to made in the National Heart, Lung and Blood Institute's National Cholesterol Education Program (NCEP) in June.

In the past three decades, great strides have been made in the prevention and treatment of heart disease with a resulting decline in cardiovascular deaths, mainly attributed to lifestyle changes. Because 50% of heart attacks present as sudden death, there is little opportunity for treatment for this group, and prevention offers the only hope. In 1990, an estimated 392,000 coronary artery bypass procedures were performed on 262,000 patients at an estimated expenditure of over \$9 billion dollars. Should all heart attack prone individuals be treated surgically, resources to defray the costs would not be available. This is true, even more so, for heart transplants. The technological treatments for heart disease such as angioplasty, thrombolytic therapy, antiarrhythmic drugs, and pacemakers are not curative. More importantly, such procedures can do nothing about the underlying process, atherosclerosis (the hardening of arteries), which is the principal cause of the problem.

It seems obvious that more effort should be directed to preventive approaches. Atherosclerosis begins in young adulthood and it may be decades before clinical disease is manifest. While we do not fully understand all of the causes of heart disease, large epidemiologic studies have identified risk factors and strategies to reduce the risk. The modifiable risk factors include high total cholesterol levels in the blood, cigarette smoking, hypertension, physical activity, obesity, and elevated blood sugar.

There has been a significant reduction in cardiovascular mortality in the U.S. due, in large part to the public's adopting a more healthful lifestyle. This underscores the importance of encouraging the medical profession to assume a preventive posture. More and more evidence is accumulating showing that atherosclerotic plaques in arteries can regress even in individuals with advanced disease.

If the current health care reform debate stresses the implementation of preventive measures, we can have a major impact on the health of the individual and the public. This is especially true of heart disease and stroke because of the considerable available knowledge about methods to prevent them. Although a cost-savings has not been placed on cardiovascular preventive services, it seems logical that they would cost less than the present medical system which is primarily responsive to established disease through expensive interventions.

By providing better access to primary care physicians, and in fact encouraging people to see a primary care physician before they are sick, many cardiovascular diseases can be prevented or identified before they become serious. Primary care physicians can work with patients to modify lifestyles and to monitor their progress.

The AHA believes that a basic medical plan should include the following basic cardiovascular preventive services: blood pressure checks, cholesterol screenings, electrocardiograms, exercise

stress tests, counseling and medications. We do not believe that these procedures should be provided to everyone on demand; the attached document details when and for whom these procedures should be done.

I would like to stress the importance of counseling at the primary care level. Periodic preventive counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium, and caloric balance and the need for a regular exercise program is critical. For those people who are at high risk with high cholesterol levels, we recommend that diet therapy with monitoring and long-term follow by a physician, registered dietician or licensed nutritionist be covered under the health plan.

Providing coverage for counseling on tobacco prevention and cessation is also very important to the AHA. Tobacco use is the number one preventable cause of death in the United States, and we know that most smokers would like to quit but can't. We are presented with a great opportunity right now provide the encouragement that they need. That coupled with increased excise taxes and FDA regulation of tobacco products would have a tremendous impact on decreasing tobacco use in this country.

Mr. Chairman, prevention--both educational and medical--has an integral role to play in health care reform. The AHA has public education programs to inform people how to reduce their risk of heart disease. Countless numbers of posters, brochures, booklets, advertisements and kits targeted to schools, businesses and healthcare sites reach millions of Americans every year with educational messages promoting good heart health. The AHA's community service programs educate the public on how to control high blood pressure, stop smoking, adopt healthy dietary habits and and be physically active.

These efforts will be greatly complemented by a comprehensive health care plan, accessible to all, that includes preventive cardiovascular health care as outlined in the attached document.

As advocates for people who suffer from cardiovascular diseases and their families, we are pleased that we are seeing progress in research, education and healthier lifestyles. Unfortunately, we still face daunting problems:

- o In 1990, heart and blood vessel diseases killed more than 930,000 Americans--more than two out of every five deaths.
- o Of the current U.S. population of about 250 million people, more than 70 million suffer some form of cardiovascular disease, in many cases with a reduction of the quality of life.
- o Heart disease and strokes are not only a threat to the elderly. More than 161,000 Americans under the age of 65 die from cardiovascular disease each year.
- o Cardiovascular diseases and stroke cost \$117.4 billion in 1993, which includes \$75.2 billion for hospital and nursing home services; \$17.9 billion for physician and nurse services; \$6.7 billion for drugs; and 17.6 billion in lost productivity.
- o The federal government's Agency for Health Care Policy and Research found in a 1991 survey that people with cardiovascular diseases are 12.4 percent more likely than the overall uninsured population to be denied private health coverage. People with hypertension, a form of cardiovascular disease, were 6.5 percent more likely to be denied coverage than the uninsured in general (2.5 percent).

Statistics such as these give the American Heart Association good reason to be concerned about the state of the country's health care system. In the United States today, some people get the message about the risk factors associated with heart attacks and strokes; some don't. Some people see a primary care physician who can detect the early stages of cardiovascular diseases; some don't. Some people get treatment from heart specialists when they need it; some don't.

It is clear that the American public is not always getting the medical attention that is available and that they deserve. For this reason, an AHA task force of volunteers developed five principles on which health care reform should be based.

First and foremost, as the health care reform debates continues, the American Heart Association calls on policymakers to ensure that all U.S. residents have access to quality medical care. Our medical system is the envy of the world, but despite that status, barriers have been erected that restrict people from taking advantage of available medical care. Even people who have insurance are sometimes barred from needed care because of a pre-existing condition.

Universal coverage of basic medical care is also imperative if we are going to improve the health of our people. Even if people had absolutely unrestricted access to care, including prescription drugs, it would do little good if they could not pay for it. Attached is a copy of an AHA report on the availability of cardiovascular drugs to the medically indigent. The report assesses the problems that many people face when they need cardiovascular drugs.

Providing coverage for preventive care gets to the heart of our interest in health care reform. So many cases of cardiovascular disease are preventable; yet, so many lives are lost or shattered because prevention and education are low on the health care priority list.

Without continuing research, we will not be able to improve the diagnosis and treatment of cardiovascular diseases. We will only make critical advances if biomedical research, research training and clinical training are recognized as integral parts of health care reform.

The AHA wants to participate in the development of guidelines for appropriate, quality cardiovascular care and see more research on methods to measure quality, outcomes and cost-effectiveness. Proper, effective and cost efficient care is necessary if the United States is going to find a solution to the health care crisis we are facing today.

The American Heart Association, in conjunction with the American College of Cardiology, has already developed ten practice guidelines on procedures ranging from electrocardiography to exercise testing to coronary angiography. The AHA and ACC are currently working on additional guidelines. The AHA would be happy to provide copies of guidelines to the committee at your request.

Death rates from heart attacks, among both men and women, have gone down substantially in the last twenty years. These statistics are the result lifestyle changes by the public and advances in medical technology and therapy. Health care providers play an important role identifying people at high risk for cardiovascular disease and encouraging them to modify their behavior. However, there is much to be done. The New England Journal of Medicine notes that "further research about the overall risk-benefit ratios of these interventions and the development of effective strategies to help implement risk-factors modifications are needed."

Tobacco use is the leading cause of preventable death and disability in the United States. Each year tobacco use kills 434,000 Americans and burdens our health care system with \$65 billion in direct medical costs and lost productivity. Tobacco use is linked to heart disease, high blood pressure, stroke, cancer of the lung, larynx, trachea, pancreas, bladder and lip and respiratory diseases. Smokers also have increased problems with colds, pneumonia, influenza and bronchitis.

Reducing the use of tobacco, by regulating its manufacture, sale, distribution, labeling, advertising and promotion, is one of the most important means available to both improve the health of Americans and lower health care costs.

Sadly, not only are active smokers at risk. Anyone who shares the air with someone who is smoking is endangered. On January 7, 1993, the Environmental Protection Agency released a report that concluded that environmental tobacco smoke (ETS) has a serious and substantial impact on the public's health. ETS is now listed as known human carcinogen along with asbestos, benzene and arsenic.

The EPA said environmental tobacco smoke is responsible for approximately 3,000 lung cancer deaths annually in the United States. The report also found that children who are exposed to ETS are a higher risk for lower respiratory tract infections, ear problems, and new and increased symptoms of asthma. The American Heart Association estimates that 35,000 to 40,000 cardiovascular disease-related deaths occur each year as a result of ETS. The American Heart Association also strongly supports a tobacco excise tax increase of at least two dollars per pack to help finance health care reform and reduce consumption. It is estimated that this increase will raise \$35 billion a year--money that could be well spent to improve access to the health care system.

Prevention is an important consideration as well. For every ten percent increase in the price of tobacco products, there will be approximately a four percent decrease in tobacco consumption and possibly a greater decrease in tobacco use among children.

Tobacco control is one the most critical health issues facing America today. Health care reform will not be complete without seriously addressing the tobacco use.

The AHA is prepared to assist the committee as it proceeds in the health care reform debate. We will be happy to provide you with more information on any of our programs at your request.



**DRAFT**  
**AMERICAN HEART ASSOCIATION**  
**BASIC CARDIOVASCULAR PREVENTIVE SERVICES**  
**CHILDHOOD THROUGH ADULTHOOD**

	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
Medical History		
Identification of Early Symptomology Including Counseling	Birth, update at 2 years, then every 4 years up to age 20	Every 5 years, every 2 years between 61-75; every year after age 75
Physical Exam		
	Birth to 18 months (2,4,6,18 months); 2-6; 7- 12; 13-14	Same as above.
Growth Chart (Children) Height & Weight	Birth, ongoing up to 13 13-18	Weight As part of physical exam
Blood Pressure		
Apparently Healthy	Age 3, every examination thereafter	If BP <130/<85 mmHg every 2 years
High Risk	Physician monitoring and follow-up at every physical	BP 130-139/85-89 mmHg every year 140- 159/90-99 mmHg confirm within two months (See attached schedule per JNC V)
Screening for Lipid Levels If Apparently Healthy		Total Cholesterol and HDL Ages 20-60: every 5 years Ages 61-75 and over optional

-2-

	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
<p>*If At High risk</p> <p>After age two children of parents with <math>\geq 240</math> mg/dl total cholesterol</p> <p>Adults with cholesterol between 200-240 mg/dl without other risk factors</p>	Total cholesterol	Recheck annually, dietary information (see attached schedule)
<p>*Fasting Lipid Profile:</p> <p>At two years of age, children with cholesterol <math>\geq 200</math> mg/dl or because of a documented history of premature cardiovascular disease in parent, grandparent, aunt or uncle, age 55 or less</p> <p>Adults with cholesterol between 200-239 mg/dl and with other risk factors, or with cholesterol <math>\geq 240</math> mg/dl.</p>	<p>Immediately</p> <p>Immediately</p>	<p>Reevaluate annually</p> <p>Reevaluate annually (see attached schedules)</p>
<p><u>Fasting Plasma Glucose</u></p> <p>Apparently Healthy</p> <p>High risk individuals between 110-130% above desirable weight, with cardiovascular disease and abnormal lipid profile</p>		<p>Every 5 years up to age 75, thereafter optional</p> <p>Every 2-1/2 years up to age 45, yearly after age 50.</p>
<p>Resting ECG</p> <p>High Risk</p> <p>Two or more risk factors and family history of premature coronary heart disease</p>		Age 40 (baseline) and above
<p>*New recommendations will be available from National Cholesterol Education Program (NCEP) later in 1993</p>		

	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
Exercise Stress Tests		High risk individuals who have 2 or more risk factors or strong family history of premature coronary heart disease or over age 40 who are planning to be in a vigorous exercise program, or those who would endanger public safety were they to experience sudden cardiac events e.g. airline pilots, fire fighters
High Risk		
Counseling		
Apparently Healthy	Parents of children of all ages, introduce AHA low fat diet at age 2; effects of passive smoking, risks of obesity, physical activity. Parents and Children age 8 and over should be counseled on diet, tobacco and substance use, physical activity and alcohol.	Periodic preventive counseling regarding dietary intake of fat, saturated, cholesterol complex carbohydrates, sodium, potassium, caloric balance, selection of an exercise program, tobacco avoidance or cessation, alcohol and cocaine use. <u>Use of Seat Belts</u>
High Risk	Children with high blood pressure and their parents should receive counseling on diet and exercise. Children with hyperlipidemia will require nutritional guidance and monitoring by a registered dietitian or licensed nutritionist, long term follow-up of lipid levels and identification and avoidance of other CV risk factors. (Follow NCEP Guidelines)	Diet therapy (AHA Step 1 and 2 diets) should be initiated in individuals with cholesterol levels between 200-240 mg/dl and over 240 mg/dl with monitoring and long term follow-up by a physician and a registered dietitian or licensed nutritionist. (Follow NCEP guidelines).
Medications		
High Risk	Elevated cholesterol levels based on NCEP guidelines indicate the need for drug therapy. It may be considered for children 10 years of age and over who have LDL-C levels higher than 190 mg/dl or >160 mg/dl and either a strong family history of premature CHD or two or more adult CVD risk factors. These children should be treated by physicians experienced in the management of lipid disorders in children.	Cholesterol lowering drugs should be considered in patients with persistent dyslipidemia based on NCEP guidelines and in many patients with established or known coronary artery disease. Pharmacologic treatment will be needed for individuals whose response to lifestyle modifications for blood pressure lowering are inadequate. Adequate compensation for drugs should be provided as needed

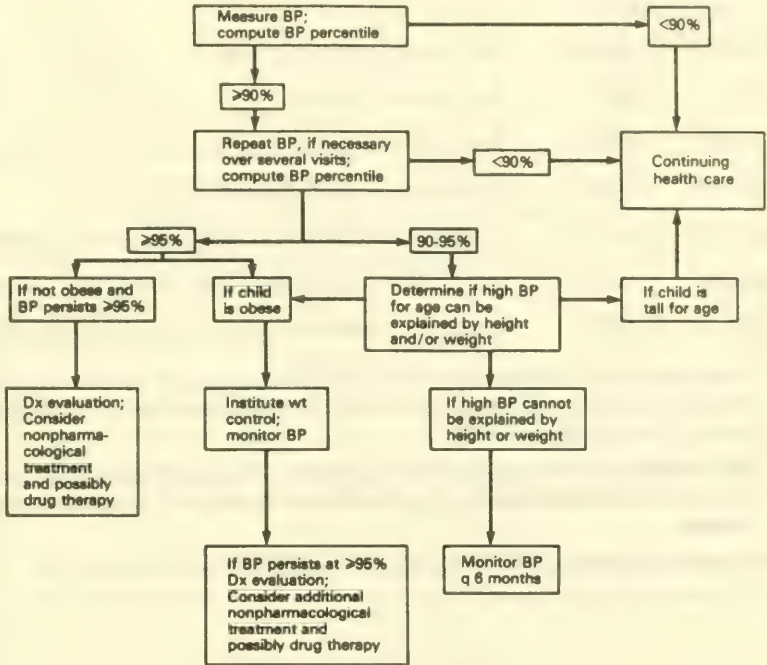


	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER																																																																																																																																																
Immunizations	<p>Should be available for all children</p> <div><div><div>IMMUNIZATION DOSE COUNTER</div><div>1st EDITION 5-92</div><div>Recommended Schedule for Immunization</div><table><thead><tr><th>Age</th><th>Birth</th><th>1-2 months</th><th>3 months</th><th>4 months</th><th>6 months</th><th>6-18 months</th><th>18-15 months</th><th>15-18 months</th><th>4-6 years</th><th>11-12 years</th><th>14-16 years</th></tr></thead><tbody><tr><td>Birth</td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1-2 months</td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3 months</td><td></td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4 months</td><td></td><td></td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>6 months</td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>6-18 months</td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>18-15 months</td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td></td><td></td><td></td></tr><tr><td>15-18 months</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td></td><td></td></tr><tr><td>4-6 years</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td></td></tr><tr><td>11-12 years</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td></tr><tr><td>14-16 years</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td></tr></tbody></table></div><p>Pregnant women lacking proof of vaccination after the first birthday or laboratory evidence of immunity should receive rubella vaccines.</p></div>	Age	Birth	1-2 months	3 months	4 months	6 months	6-18 months	18-15 months	15-18 months	4-6 years	11-12 years	14-16 years	Birth	✓											1-2 months		✓										3 months			✓									4 months				✓								6 months					✓							6-18 months						✓						18-15 months							✓					15-18 months								✓				4-6 years									✓			11-12 years										✓		14-16 years											✓	<p>Influenza-Pneumococcal Age 65 and over, high risk groups</p>
Age	Birth	1-2 months	3 months	4 months	6 months	6-18 months	18-15 months	15-18 months	4-6 years	11-12 years	14-16 years																																																																																																																																							
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	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
History of Acute Rheumatic Fever	Penicillin Prophylaxis	
Valvular heart disease with procedures	Penicillin with procedures	

FIGURE 7

# ALGORITHM FOR IDENTIFYING CHILDREN WITH HIGH BLOOD PRESSURE





**TABLE 4. RECOMMENDATIONS FOR FOLLOWUP  
BASED ON INITIAL SET OF BLOOD PRESSURE MEASUREMENTS  
FOR ADULTS AGE 18 AND OLDER**

Initial Screening Blood Pressure (mm Hg)*		Followup Recommended†
Systolic	Diastolic	
<130	<85	Recheck in 2 years
130-139	85-89	Recheck in 1 year**
140-159	90-99	Confirm within 2 months
160-179	100-109	Evaluate or refer to source of care within 1 month
180-209	110-119	Evaluate or refer to source of care within 1 week
≥210	≥120	Evaluate or refer to source of care immediately

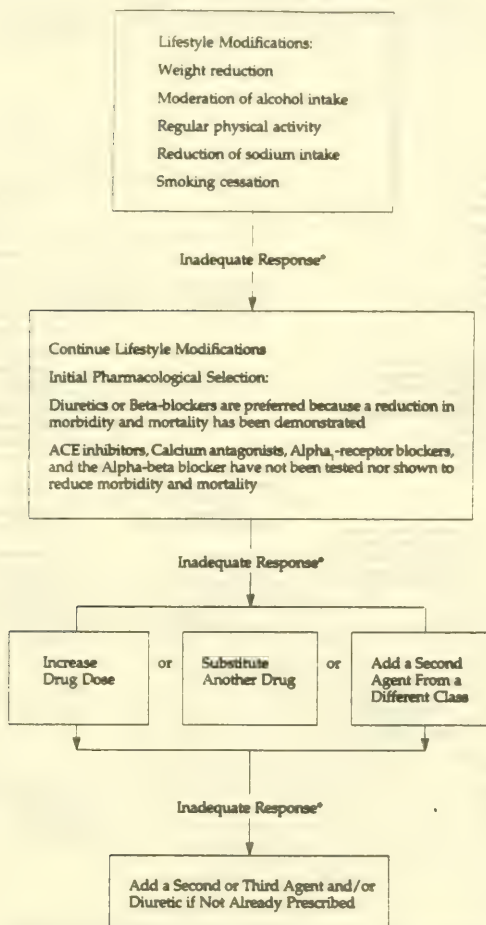
\* If the systolic and diastolic categories are different, follow recommendation for the shorter time followup (e.g., 160/85 mm Hg should be evaluated or referred to source of care within 1 month).

† The scheduling of followup should be modified by reliable information about past blood pressure measurements, other cardiovascular risk factors, or target-organ disease.

\*\* Consider providing advice about lifestyle modifications (see Chapter III).

*The Fifth Report of the Joint National Committee  
on Detection, Evaluation and Treatment of HBP.  
NIH — NHB 1983*

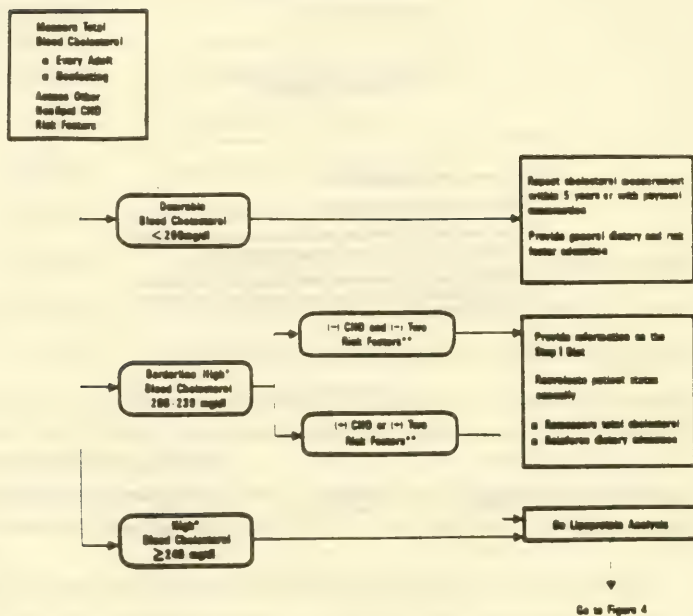
FIGURE 4. TREATMENT ALGORITHM



\* Response means achieved goal blood pressure, or patient is making considerable progress towards this goal.

FIGURE

# 3 – Initial Classification Based on Total Cholesterol



\* Must be confirmed by repeat measurement; use average value.

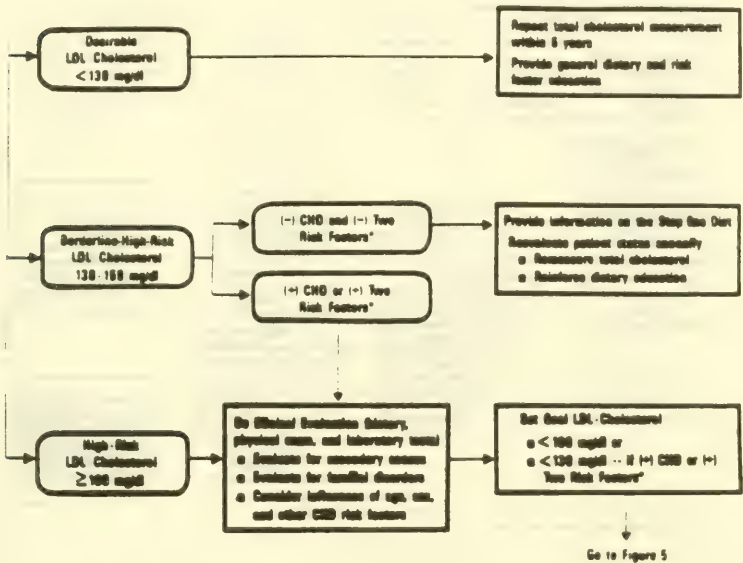
\*\* One of which can be more than 1 (see Table 2).

FIGURE

# 4 – Classification Based on LDL-Cholesterol

## Be Lipoprotein Analysis

- 12-hour fast
- Measure total cholesterol, HDL cholesterol, and triglycerides
- Estimate LDL cholesterol = total cholesterol - HDL cholesterol - (triglycerides/5)
- Average of 2 to 3 measurements, 1 to 6 weeks apart



\* One of which can be made sex (see Table 2).



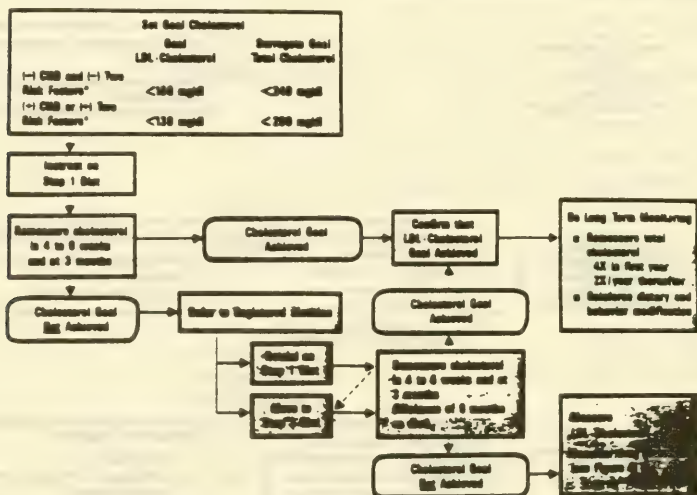
‡ inadequate Response to Diet

A patient who has undergone the goals of a certain treatment program is not considered to be a patient unless he is considered as being in a candidate position for the next treatment program. Thus, the patient must be in a position to be treated in a subsequent program. Even though a patient may have completed a treatment program, he is not considered a patient unless he is in a position to be treated in a subsequent program.

- Patients with more severe elevations of serum cholesterol (mean  $260 \pm 100$  mg/dl) and triglyceride concentrations (mean  $160 \pm 100$  mg/dl) than those with mild elevations (see Appendix 1) had a mean age of  $54 \pm 10$  years. For these patients see Appendix 1. The mean serum total cholesterol was  $260 \pm 100$  mg/dl. A low-dose statin therapy before adding drugs to the regimen

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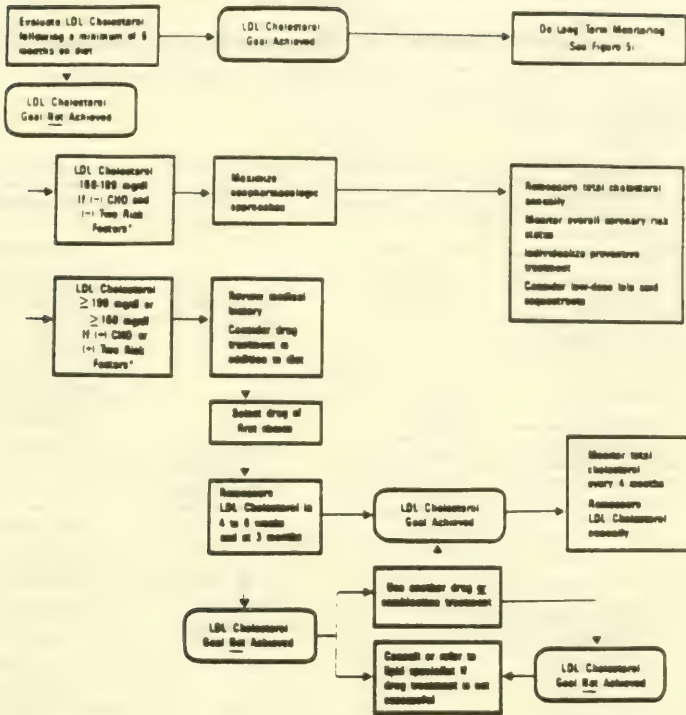
## 5 - Dietary Treatment



\* One of which can be male sex (Table 2)

C O U R S E

## 6 - Drug Treatment



\* One of which can be more see Table 21

Figure 2

## Classification, Education, and Followup Based on LDL-Cholesterol

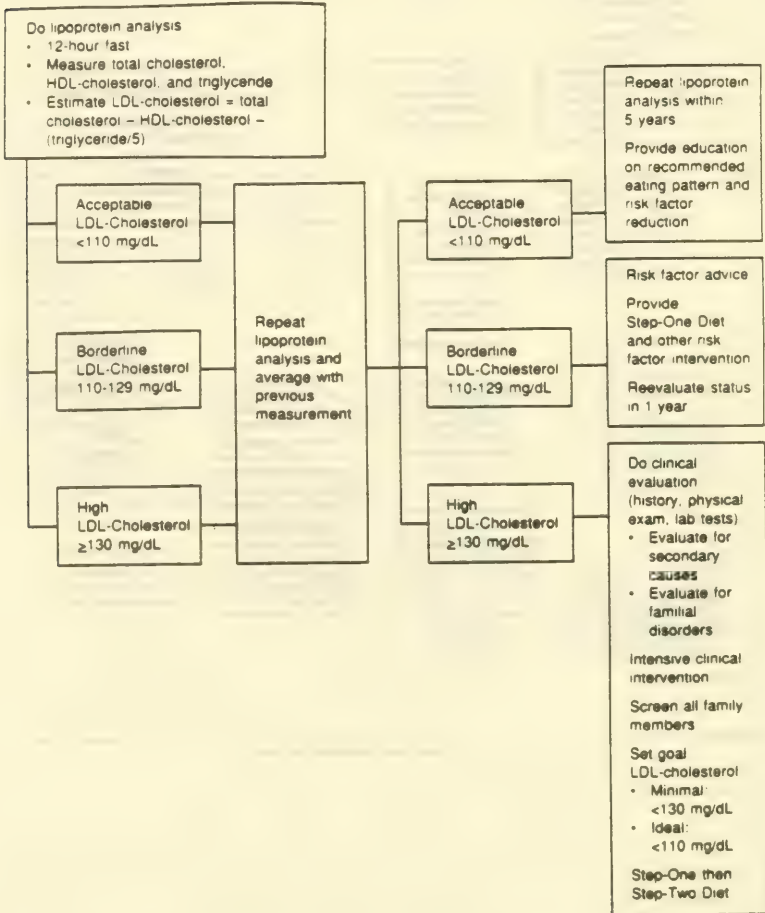


Figure 1  
Risk Assessment

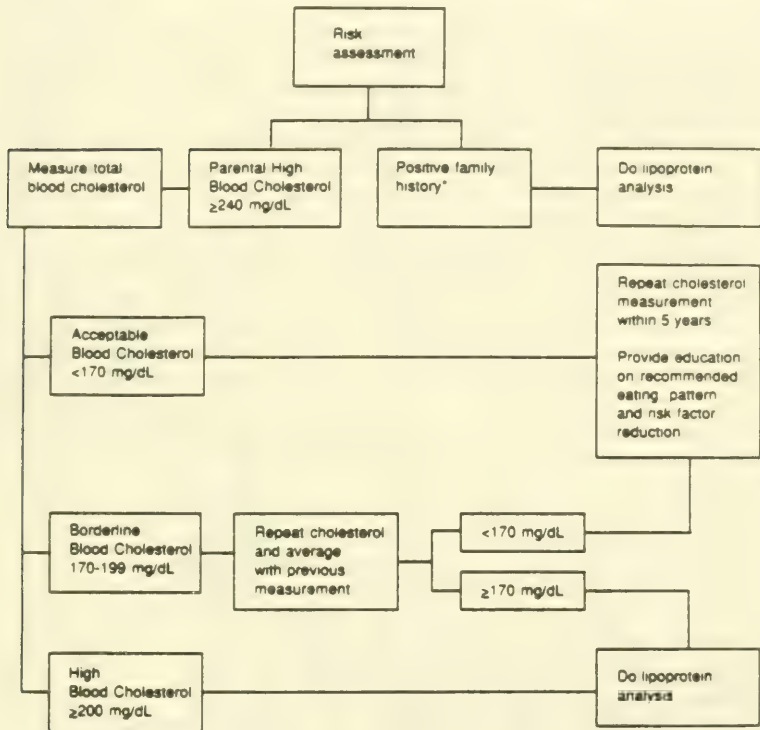
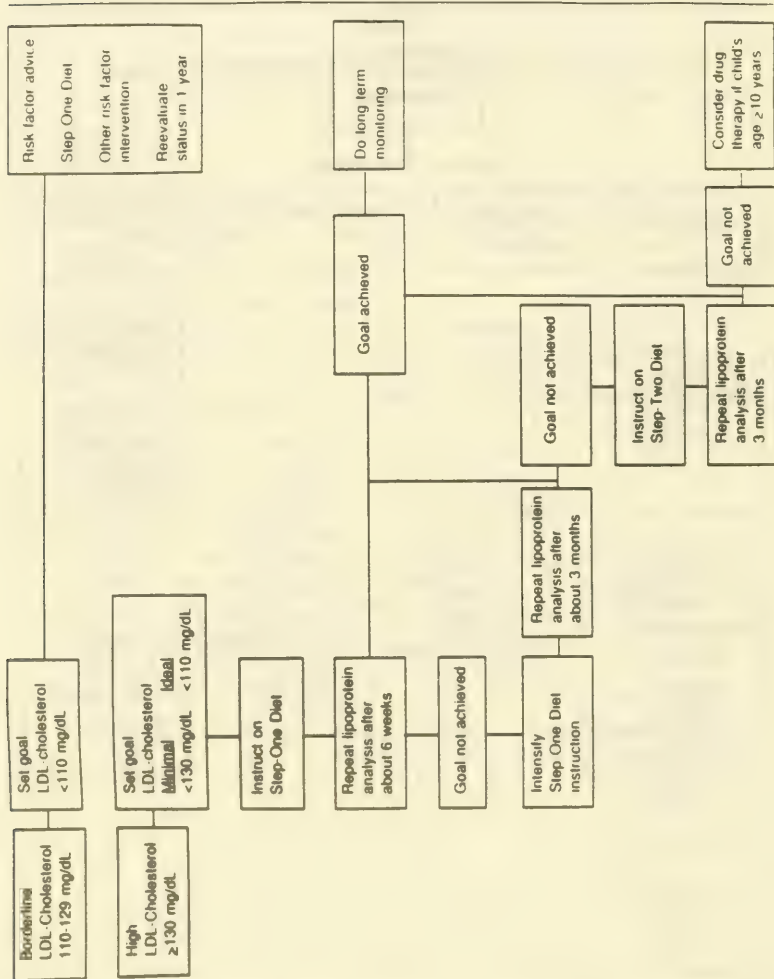




Figure 3

## Diet Therapy



Mr. ANDREWS. Thank you, Dr. Francis.  
Mr. Thomas.

**STATEMENT OF PETER W. THOMAS, ON BEHALF OF AMPUTEE COALITION OF AMERICA, AMERICAN STATE OF THE ART PROSTHETIC ASSOCIATION, AND THE AMERICAN AMPUTEE FOUNDATION**

Mr. THOMAS. Thank you. My name is Peter Thomas, and I am representing the Amputee Coalition of America, the American State of the Art Prosthetic Association, and the American Amputee Foundation. Those are three nonprofit national groups of not only amputees who use artificial limbs and people who use orthoses, or braces, but also the people who design and fit these devices.

In 1974, I was involved in a car accident where I lost both my legs below the knees, and since then have received 12 sets of artificial limbs over 19 years from 8 different providers throughout the country. I have had virtually every type of device available on the market today and speak from some experience when I say that artificial limbs have become vastly lighter, more flexible, more functional devices, and allow people with amputations to really get back to what they were doing prior to their amputations and be extremely functional.

I think Jody Wildy's testimony is an extremely good example of that precise comment, and I would really like to underscore the absurdity that an HMO or that a health insurance plan would propose to cover rehabilitation of someone who loses their limbs, but not cover the artificial limbs in order to allow that person to walk.

There are many issues that the groups I represent are very concerned with in the health care reform debate, but I wanted to leave you with four major issues today.

The first is that orthotics and prosthetics, or artificial limbs and orthopedic braces, must be included as a basic benefit in the reformed health care system. We understand that the President's task force is considering different models for the funding of durable medical equipment, of which orthotics and prosthetics are usually considered, and we understand that three of the four models being considered could treat DME and orthotics and prosthetics as a supplemental benefit and not a core benefit or basic benefit.

We strongly disagree with this approach. While this is a very small sector of the health care industry, some of these devices can be unaffordable to people who need them. We believe that these costs need to be widely spread.

Second, a very important point is that not only must orthotics and prosthetics be included in the basic benefit package, but there must be some standard for the functional appropriateness of these devices. You could throw a set of World War II-technology artificial limbs on me, and essentially I could walk. But I couldn't play golf, as I do, and I couldn't snow ski and I couldn't work as well as I do and do the types of things that I am accustomed to doing.

There needs to be some functional element, some functional assessment to the provision of these devices.

There also must be flexibility in this reformed health care system so that I can access services outside of the health care network that I might happen to be a part of. For instance, I currently receive my

artificial limbs from Florida and have worked with the person down there for several years now and really am very comfortable with the relationship there. I have not been satisfied with several other providers that I have gone to for artificial limbs. If that were prevented from happening in a reformed health care system, I think that would be a step in the wrong direction. So I stress that flexibility is an extremely important point to ensure that consumers have access, not only choice in provider and practitioner of these devices, but also in the type of device that the person ultimately winds up receiving.

Lastly, the point that has been repeated here today—that rehabilitation, and specifically orthotics and prosthetics, is extremely cost-effective. It gets people back to work. It gets people back doing the types of things they want to do. It keeps people off of maintenance and income programs. And it allows people to retain the quality of life that they desire.

No better illustration is Gene McGuane, who was an amputee in his 60s living down in Florida, who was covered by an HMO and because of a loss of weight of 70 pounds due to kidney disease, needed a new set of artificial limbs. To make a long story short, he never received those limbs. He never received the functionally appropriate limbs that he needed and wound up about a year and a half in a wheelchair and ultimately died shortly thereafter, not directly as a result of that, of course, but certainly his last years of life were not spent in the way that he had hoped they would be. His wife does believe that the inactivity caused as a result of not receiving those limbs contributed to his early passing.

If we can learn anything from Gene McGuane's death, let us not repeat the mistakes that have been made with him. Let's try to incorporate his experience into our thinking in reforming our health care system.

Thank you very much.

[The prepared statement follows:]



## **TESTIMONY OF PETER W. THOMAS** **Amputee Coalition of America**

**Distinguished Chairman and Members of the Subcommittee:**

My name is Peter Thomas and today I am testifying on behalf of a group of individuals with disabilities who have never formally testified before Congress on any issue, let alone on the vital issue of national health care reform. I speak on behalf of this nation's approximately two million amputees who utilize artificial limbs (prostheses) and millions of people with physical disabilities who utilize orthopedic braces (orthoses) in order to maintain active, independent and productive lives.

### **Organizational Support**

I specifically represent the Amputee Coalition of America (ACA) which represents the national voice of amputees. The ACA is a national non-profit coalition of approximately 100 amputee support groups representing tens of thousands of members. I also speak on behalf of two other national groups: The American State of the Art Prosthetic Association (ASOTAPA) which is a non-profit organization comprised of prosthetists, orthotists, and consumers interested in the technological and functional advancement of artificial limbs and orthopedic braces, and the American Amputee Foundation (AAF) which assists amputees across the country in accessing prosthetic and orthotic care. This testimony is also supported by the organized field of prosthetists and orthotists, namely, the American Orthotic and Prosthetic Association (AOPA). In addition, the Consortium for Citizens with Disabilities (CCD) is highly supportive of our position that orthotic and prosthetic services must be included in the basic package of benefits in a reformed health care system.

### **Personal History**

I am intimately aware of the importance of artificial limbs first-hand. In 1974, at the age of 10, my family and I were involved in a severe car accident which resulted in the loss of both of my legs below the knees and the death of my younger brother. With the help of a very loving and supportive family and group of friends, as well as an excellent rehabilitation program with a great deal of physical therapy, and the benefits of assistive technology namely my artificial limbs, I have been able to accomplish goals that I never thought possible lying in that hospital bed in 1974. I am an avid downhill skier in the winter and golfer in the summer; I attended Boston College and Georgetown University Law Center and currently practice law here in Washington, D.C.; I have written a book on the Americans with Disabilities Act, and I participate in virtually any physical activity that I wish; I walk everywhere on my artificial limbs, rarely use a cane, and never use a wheelchair.

### **Cost-effectiveness**

My point is simply that the provision of functionally appropriate artificial limbs and braces to people with amputations and other disabilities can have significant implications on a person's life and is extremely cost-effective. Rehabilitating people with orthopedic impairments and providing them with the orthotic and prosthetic services they require in order to maintain or enhance function creates a whole host of cost-effective implications. By providing orthotic and prosthetic devices that are not only medically necessary but are functionally appropriate to the particular needs of the individual, the costs of frequent replacement devices for nonfunctional limbs, the costs of complications and deterioration as a result of inappropriate devices, and the costs of secondary medical care and hospital stays to correct these medical problems significantly decreases. In addition, the costs to society for income maintenance programs and social supports also decreases as people with disabilities using these assistive devices become more active and independent, securing employment and participating in the mainstream of American life.

### **Gene McGuane: A Prime Example**

There is no better illustration of the cost-effectiveness of functional prosthetic devices than the case of Gene McGuane.

Mr. McGuane was a fine gentleman in his 60's living in Florida during the past few years. As a result of circulatory problems, his legs were amputated below the knees in 1987. Mr. McGuane successfully rehabilitated himself and adapted to the artificial limbs provided to



him. But a bout with kidney disease resulted in substantial weight loss and significantly changed the shape of his residual limbs, necessitating a new set of prostheses that would not aggravate his circulation problems.

Mr. McGuane was covered under a Florida Health Maintenance Organization (HMO) for Medicare beneficiaries. The HMO sent Mr. McGuane to an HMO physician who prescribed lightweight, flexible, and functionally appropriate artificial limbs to address Mr. McGuane's circumstances. The prosthetist to which Mr. McGuane was referred was highly trained in the type of limbs prescribed by the HMO's physician. Because these limbs were slightly more expensive than Mr. McGuane's previous limbs, the HMO rejected the claim immediately and referred Mr. McGuane to several other prosthetists before the HMO eventually approved a "functional equivalent" to the device prescribed and contracted with the least expensive bidder in Mr. McGuane's region to provide the devices.

Not surprisingly, the less expensive devices were of less quality and did not meet the functional needs of Mr. McGuane. Mr. McGuane was then referred to the HMO's "gatekeeper" physician to verify the medical necessity of the limbs he was originally prescribed, even though this gatekeeper admitted he knew nothing about prosthetics. When Mr. McGuane protested to his HMO that the less functional artificial limbs could put him back into the hospital with medical complications, the HMO responded that there would be no problem in paying for additional hospitalization, but that they could not pay the additional cost for the artificial limbs that were originally prescribed.

Mr. McGuane died a few months later in the Spring of 1992 without the artificial limbs originally prescribed to him and unable to wear the artificial legs that were said to be the functional equivalent of the limbs prescribed. His last year of life was primarily spent in a wheelchair or in pain on artificial limbs that were not only functionally inappropriate for his needs but that contributed to medical complications. Mr. McGuane's wife, Mary, said recently, "Gene was an active man who just wanted the independence to run his own life." She believes that Gene's life ended early due to the anguish brought about by this delay and his inactivity brought on by an insurance company's indifference or refusal to understand his functional needs and adequately address them.

The biggest tribute we can now give Gene McGuane is to learn from the mistakes of the system that he encountered and to reform this nation's health care delivery system so that this institutional indifference to the quality of people's lives does not persist.

### **The Importance Of Prosthetics And Orthotics As A Basic Benefit**

As the President's Task Force on National Health Care Reform and the Congress tackle the monumental challenge of comprehensively reforming America's health care delivery system, America's individuals with disabilities who require the use of artificial limbs and orthopedic braces to lead more active and productive lives, as well as the practitioners who design and fit these devices, need to be recognized in this important debate.

Great strides have been made in the technological and functional enhancement of prosthetic and orthotic devices in the past decade. Artificial limbs and orthopedic braces have become lighter, more comfortable, and more functional. Unless health care policy makers understand and recognize in any reform package the unique nature of orthotic and prosthetic devices, the service delivery system required, and the populations they serve, this nation's two million amputees using prostheses and millions of disabled users of orthoses could take several giant steps backward.

### **The History Of Orthotics And Prosthetics**

There was a time, not many years ago, when the loss of a limb meant a life with a heavy, often painful wooden and leather artificial leg or arm, if it could be fit to the amputee at all. There was a time when persons with disabilities such as cerebral palsy, scoliosis, spinal cord injury and other physical disabilities were forced to wear unsightly heavy steel and leather orthopedic braces to support themselves and remain functional. This World War II generation of devices gave way to artificial limbs made of plastic laminated woods with stiff ankled feet

which resembled that of a mannequin, and orthopedic braces which used aluminum supports. Those days, fortunately, are largely in the past, just as the days when gas filled tubes were replaced by transistors in our televisions and radios.

### **Recent Advances**

Today's advanced generation of prostheses and orthoses are lightweight, streamlined, dynamic and more accurately replicate human function. Advanced thermoplastics and molding techniques have revolutionized the fit and function of prostheses and orthoses by allowing for the custom development and anatomical design of flexible, more comfortable tissue interface materials. Carbon fiber composites, titanium, and other metal alloys from the aerospace industry have drastically decreased the weight of these devices while increasing their strength and durability. New prosthetic and orthotic fitting and self-suspension techniques have allowed practitioners to design devices which more appropriately meet the needs of our nation's amputees and other individuals with disabilities by eliminating the need for cumbersome straps, belts and harnesses. Finally, new forms of myoelectric and mechanical control systems of prostheses and orthoses have ushered in new standards of function and control; standards that tap into muscle-electric impulses and computerized componentry, along with hydraulic and other sources of power.

### **The Effects Of Recent Advances**

This new generation of prostheses and orthoses has had a profound effect upon restoring the activity level and quality of life of amputees and other individuals with physical disabilities. Consumers of these devices are adapting quicker to their disabilities, functioning better, and returning to their desired vocational and recreational activities. These technologically appropriate devices are medically necessary in order to provide and restore enhanced function in people with disabilities. These devices, however, are obviously more expensive than the devices they preceded, at least in the short term. Of grave concern to amputees and users of orthoses is the possibility that across-the-board cost-containment strategies may stifle the recent availability of functionally appropriate prosthetic and orthotic devices.

### **Containing Health Care Costs**

There currently exists a wide variety of prosthetic and orthotic devices available to consumers that range from the out-dated to the highly advanced. This produces a significant variance in the range of fees for prosthetic and orthotic services. The existing fee schedules under Medicare and the Veterans Administration (VA), for instance, have not kept pace with the rate of technological improvements and, hence, skew median orthotic and prosthetic reimbursement rates downward. In addition, reimbursement rates are often discounted in the Medicare and VA fee schedules because of relative bargaining position dynamics and the provision of services in bulk. These factors converge to create a situation where Medicare reimbursement rates for orthotics and prosthetics are approximately 30% of the private sector reimbursement rates. Artificially low reimbursement rates on the services that orthotists and prosthetists provide will ultimately have a negative impact on the orthotic and prosthetic consumer.

### **The True Impact On Orthotics And Prosthetics On Health Care Costs**

In the national effort to contain the rising costs of health care, the orthotic and prosthetic field is ready to assume its share of the burden. But as consumers, who stand to lose the most, we ask that the Subcommittee bear in mind the true impact of orthotics and prosthetics on the health care crisis. For instance, \$900 billion is spent on health care annually of which the entire orthotic and prosthetic industry represents approximately \$1 billion annually. It is estimated that Between \$700 and \$800 million of this figure is direct expenditures on patient care. The Medicare program expended \$132 billion in FY 1992, of which the total of all orthotic and prosthetic expenditures came to approximately \$250 million, less than one half of one percent of the program. With respect to health care inflation, the Medicare program expended 12% more in FY 1992 as it did in FY 1991. By contrast, orthotic and prosthetic reimbursement rates under the Medicare Program have risen a total of just 12% in the past decade, at times as low as zero, and never more than five percent annually.

Current health care trends have created a dilemma for practitioners in providing prosthetic and orthotic services which will likely be exacerbated by system-wide competitive bidding, where the incentive is placed on the least expensive care with little emphasis on the functional appropriateness of these devices. This places the prosthetic and orthotic practitioner in the untenable position of either providing devices at higher cost--and with greater success rates in terms of increased function and decreased complications and follow-up care--or providing consumers with lower cost, less functional and less appropriate prostheses and orthoses.

### **The Specialized Nature Of Orthotics And Prosthetics**

Any health care reform proposal must recognize the unique nature of prosthetic and orthotic services within our national health care delivery system. Unlike most medical services, which are largely uniform and homogeneous in quality and delivery, significant variations exist in the delivery of quality orthotic and prosthetic services, primarily due to the explosion in technology over the past decade. Prosthetic and orthotic services, unfortunately, have been inappropriately lumped into the category of durable medical equipment ("DME") until the recent past.

Custom designed and fit prostheses and orthoses are fundamentally different from durable medical equipment in that their production combines the disciplines of medicine and engineering and is as much an art as it is a science. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes, and complex contours, is indeed inherently different from off-the-shelf durable medical equipment, such as wheelchairs that do not require customization, crutches, walkers, etc., which can be rented and often reused by more than one person. Prosthetic and orthotic services should be recognized as separate and distinct from DME both legislatively and regulatorily.

### **The Separate Treatment Of DME And Orthotics And Prosthetics**

The orthotic and prosthetic profession is very different from the DME industry in that orthotics and prosthetics has a defined body of clinical and technical knowledge, and a core of specially credentialed practitioners, with formalized education provided by well-established post-baccalaureate education programs offered at eight major American universities.

It is important to note that the significant differences between orthotics and prosthetics and DME were recognized by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). In practice, however, the statutory separation has been in name only, as no meaningful separation in the treatment of orthotics and prosthetics has occurred with respect to the Health Care Finance Administration's (HCFA's) philosophical and financial practices. The past practice of continuing to inappropriately group orthotics and prosthetics with DME, despite the OBRA '90 recognition of separation, has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in the health care delivery system.

The President's 1994 budget proposes to once again treat orthotic and prosthetic services the same as DME by inappropriately placing these highly specialized patient services with the provision of durable medical equipment which is primarily sold or rented to support certain treatment modalities. We believe that this approach is not a step in the right direction and strongly support the separate treatment of orthotics and prosthetics from DME for coverage and reimbursement in the Medicare program. This is not to say, however, that the provision of durable medical equipment to people with disabilities is unimportant or that all DME can be considered "off the shelf." Some customized wheelchairs, for instance, are extremely important to the functional capacity of their users and should be recognized as such. In addition, DME greatly assists the amputee population in mobility, whether or not the amputee is able to wear artificial limbs or not.

### **The Concerns of Orthotic and Prosthetic Consumers**

The greatest concern among consumers of prosthetic and orthotic devices, and the practitioners who design and fit these devices, is that national health care reformers, in their



efforts to control costs, will jeopardize access to quality care by limiting the use of functionally appropriate prostheses and orthoses. Just as we would never return to performing open surgical procedures as opposed to arthroscopic surgical procedures in order to contain health care costs, we must not place prosthetic and orthotic consumers in the position of settling for devices that are inadequate for their needs and that will create costs in the longterm.

Prosthetic and orthotic technology is currently in a state where almost no American need contemplate the idea of never walking or functioning again in the event of losing a limb or developing a significant disability. A reformed health care system must build upon these recent strides, not reverse them and return to technology of decades past in an effort to contain short-term costs. If functionally appropriate prosthetic and orthotic devices are not considered medically necessary under a reformed health care system, the long-term costs associated with out-dated prosthetic and orthotic services will surely be enormous.

### **Orthotic And Prosthetic Principles In Health Care Reform**

As this Subcommittee prepares to review the health plan proposed by the President's Task Force on National Health Care Reform and develops its own proposals to comprehensively reform this nation's health care system, we strongly urge consideration of the important principles outlined in this testimony. To reiterate and summarize:

1. In order to meet the special health care needs of people with disabilities, the importance of prosthetic and orthotic services must be recognized and included in any basic benefits package.
2. Prosthetic and orthotic devices that are medically necessary and functionally appropriate for amputees and others with disabilities must be the standards upon which coverage and payment determinations are made.
3. Prosthetic and orthotic devices that meet the functional needs of the consumer are cost-effective by decreasing the need for replacement of non-functional devices, decreasing the costs of medical care due to unnecessary complications and secondary disabilities, and decreasing long-term care and income supports as people with disabilities become more functional and independent.
4. Given the unique and customized nature of prosthetic and orthotic services, the various degrees of severity of individual disabilities, and the significant technological differences in the devices practitioners provide, consumers must have the right to choose their practitioner, even if they must travel outside of their health care "network" to receive those services without being penalized. Consumers should not be required to first receive care from all practitioners within their local health care network before they are allowed to choose their desired practitioner outside of their network of providers, with whom they may have a long-standing relationship.
5. Flexibility must be built into the reformed national health care system whereby prosthetic and orthotic consumers have the right to participate in choosing the appropriate device, in consultation with a knowledgeable physician and prosthetic or orthotic practitioner, that meets the consumer's vocational and functional needs. Functional appropriateness and quality care must not be compromised in the effort to contain costs.
6. To ensure quality care to our nation's individuals with disabilities, it is essential that prosthetic and orthotic services be provided (and reimbursed by third party payors) in a timely manner by qualified practitioners within facilities that are technologically equipped to provide custom fit and anatomically designed prostheses and orthoses. These highly specialized services should be provided by certified practitioners and within facilities accredited by the American Board of Certification in Orthotics and Prosthetics.
7. The separate payment classification of prosthetics/orthotics from durable medical equipment in the Medicare program appropriately recognizes the unique and customized nature of professional prosthetic and orthotic services and anatomically designed devices. Prosthetics and orthotics should be treated as a separate legislative and regulatory category for the purposes of coverage and reimbursement as they are fundamentally different from durable



medical equipment (i.e., wheelchairs, canes and crutches which can be rented and/or reused by more than one person).

### **Orthotics And Prosthetics Must Be A Basic Benefit**

It is our understanding that the President's Task Force on National Health Care Reform is currently considering four models for the treatment of durable medical equipment, which includes orthotics and prosthetics (O&P), in a reformed health care system. Three of the four models treat DME and O&P as a supplemental or "wrap-around" benefit, not part of the basic benefit package. We strongly object to this approach. Inclusion in the basic benefit package of orthotics and prosthetics and most durable medical equipment is extremely important in that it enables people with disabilities to lead active and independent lives. By making DME and O&P a supplemental benefit that would only be reimbursed if the person requiring these devices purchased a supplemental benefits policy, the cost of these policies would be priced out of the reach of most people. These costs must be spread across all payors because anyone may need these devices at anytime throughout their lives.

### **Other Principles Of Reform**

Although we have focused on health care reform principles that are most applicable to orthotics and prosthetics, we also strongly support the inclusion in the basic package of benefits of in-patient and out-patient rehabilitation services, including physical therapy, occupational therapy, and all forms of durable medical equipment. We support the elimination of significant barriers to health care such as pre-existing condition exclusions and support a systematic shift to community rating of insurance premiums. Finally, we support annual limits on out-of-pocket health care expenses to ensure patient financial protection and strongly believe in the establishment of protections against underservice inherent in managed health care delivery models.

### **Conclusion**

Prosthetic and orthotic consumers and practitioners applaud the President's Task Force, this Subcommittee, and the 103rd Congress in the effort to comprehensively reform this nation's health care system. Expanded access to health care for millions of Americans will ultimately mean that more amputees and other individuals with disabilities in the future will be able to obtain the prosthetic and orthotic services they need. It is extremely important, however, that in an attempt to contain the short-term costs of prosthetic and orthotic devices, the long-term costs of functionally inappropriate devices are not overlooked. Prosthetic and orthotic devices that are functionally appropriate and medically necessary for the optimal function and needs of the consumer must remain a priority in providing quality care as we strive to provide universal access to our nation's health care system.

Thank you for this opportunity to testify on this critical issue and I welcome any questions you may have at this time.

Mr. ANDREWS. Thank you very much, Mr. Thomas.

I had the opportunity a few weeks ago to tour the Texas Institute for Rehabilitation and Research in the Texas Medical Center in Houston. TIRR is a place you all would probably be very familiar with. It is an amazing resource with assets and talent and people that need help to be able to help themselves.

I think the three of you made some excellent points today. Two of the most important, I think, are that, first of all, to take a person that has become literally an economic burden on a local community because they are unable to earn income and they are having to receive assistance, probably for the first time in their lives, and to encourage that person to be a productive citizen again is an important goal from an economic standpoint.

Also, as we look to ways in this health care reform debate to find efficient, cost-effective, less expensive ways to deliver health care and maintain a healthy populace, rehabilitation centers and clinics, theories and practices, are one of the ways that I think is very important to achieve these goals of a more cost-effective health care delivery system.

So much has been learned in this area of science and medicine just in such a short period of time. Mr. Thomas, you mentioned World War II technologies. I suspect in the last decade or so we have learned a great deal.

I have a young friend in Houston who was out jogging a few years ago, and a tree fell on him and he was paralyzed from the waist down. He had just gotten out of law school and thought his life was over.

He spoke to me last week when I visited TIRR, and he is now a district judge in Houston, very successful, happily married, and more than just a productive member of society. He is a leader in Houston and a real inspiration, just like I know that you are and will be even more so in the future. And that is also a very important goal. I wish you well in that endeavor.

One of the things also, Ms. Stovall and Dr. Hoots—I would like to ask you to put on another hat of cancer research. I know at M.D. Anderson one of the things that is of a lot of concern is that we include the patient care costs for clinical trials. I wonder if you would give us your thoughts about that and why you think that is important.

Ms. STOVALL. Well, it is an excellent question because it really speaks to one of the things that we are very, very concerned about; that is, that the out-of-pocket expenses for people with cancer can be astronomical. And in the case of clinical trials, where insurers regard them as investigational or experimental, it just denies treatment across the board. And so the enrollment for them is less than adequate.

Our thoughtful approach to this is to be sure—I think the cost-effectiveness factor has been looked at by us by saying that we have looked at a very appropriate range of peer review clinical trials, the ones that we feel are adequate and should be covered, and they do represent state-of-the-art treatment for people with cancer. And more people need to know about them and be enrolled in them.

Mr. ANDREWS. Dr. Hoots.

Dr. HOOTS. I think pulling from the childhood leukemia example may help answer that question. Survival now and cure for childhood leukemia is in excess of 65 to 70 percent. When you are talking about clinical trials, you are talking about differentiating between very, very successful therapies. There are a few outlying cell types that cause particular problems. In those cases, it is very important—because in many cases they are the rarer forms—that you be able to measure some sort of increased intervention, because the mortality is higher in that subgroup than in the overall standard group. The only way to do this is by doing clinical trials.

I think it is incumbent on everyone who looks at this to look at both the role that therapy plays in research and vice-versa. It is not just on the cancer side. One of the things we do in hemophilia as well, is we coordinate our research services so that they augment the care patients receive; they get more contact, but they also get state-of-the-art treatments. This is the case for new growth factors in cancer and for recombinant Factor 8 for hemophilia.

All clinical trials are, if you want to really split hairs, research, but they are being measured against very well-established and proven efficacious therapies. And all that is being done is trying to increase survival, decrease morbidity by doing the comparisons. In that sense, it is therapy in the finest sense of the word.

Mr. WILSON. Mr. Chairman, if I may?

Mr. ANDREWS. Sure, Mr. Wilson.

Mr. WILSON. That issue is also very, very relevant for people living with HIV disease and AIDS. For many, many people, clinical trials are the only form of treatment at all. Absent clinical trials, people die. There is no place for them to go. And so the issue of patient care being a part of the clinical trial spectrum and being included as a cost factor is very, very important for this population.

Mr. ANDREWS. Dr. Francis, you touched on an issue that has always been of interest to me, and that is tobacco use and what it means to society in terms of cost. About 1,000 people die every day from using tobacco products, and we spend as taxpayers about \$24 billion a year just to take care of people that get sick from smoking.

Regrettably, demographically, the people that are preyed on the most by the tobacco industry tend to be the poorest. They are in our inner city areas more so than other parts of the country. I can always tell different parts of my congressional district as I drive around Houston by the tobacco billboards. Regrettably, it is the people that are least educated, that are young, and that are poor that tend to be the targets of the tobacco industry to take the place of the people that die from using their products.

I wonder in particular in areas like Harlem, what do you think increasing the tobacco tax could mean to young teenage smokers? Fully about half of the new smokers every day are under 12 years old, and 90 percent of the new smokers are under 19. And I wonder, if we were able to increase the tobacco tax, if you think that would have a positive impact in places like Harlem?

Dr. FRANCIS. I would very strongly adhere to that recommendation. Clearly raising the tobacco tax has a major impact on reducing smoking in low-income areas, and particularly among young people. In Harlem, it is a very severe problem and actually relates to the discussion we just heard on cancer as well as HIV, since can-



cer is often undiagnosed in our population to a much greater extent because of a lack of access to care. And the high prevalence of smoking makes that a particularly severe problem in terms of lung cancer. Also for cardiovascular disease as well as for lung cancer, smoking in our community is a major risk factor.

Mr. ANDREWS. Well, I thank all of you. This has been a very good panel, and I appreciate very much your testimony.

I thank all of you for coming today, and please let's start to my left. Mr. Moffitt, if you would please go first. Just for the benefit of moving forward, we have several panels today, and if you would, please, give us a narrative of your written testimony. Your written testimony will be made a part of the official record. The lights are to help guide you. When you see the yellow light, please try to wind up your testimony. Then when the red light goes on, please try to end your testimony so we can move down the panel and be sure to cover everyone today.

So, Mr. Moffitt, after you, we'll go down the row, and if everyone would please introduce themselves and who you represent.

Mr. Moffitt.

#### **STATEMENT OF R. GENE MOFFITT, PRESIDENT, AMERICAN AMBULANCE ASSOCIATION**

Mr. MOFFITT. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, my name is Gene Moffitt, and I am the president of the American Ambulance Association, which is the national trade association representing businesses who provide fee-for-service ground ambulance transportation. Our association primarily represents all forms of private providers, but also includes public utility models, volunteer ambulance corps, hospital-based services, and government owned and operated services. We thank you for the opportunity to testify today on the standard benefits package which is likely to be a part of the President's health care reform.

As a provider of emergency medical care and transportation, we are an integral part of the overall health care delivery system. As a result, we recognize that there is a crisis in the American health care system from firsthand experience. Experts in the health care field often talk of the 37 million Americans who have no insurance. We treat those people on a daily basis and will continue to provide critical medical care to those in need, regardless of their ability to pay. However, as you can well imagine, our ability to continue providing quality emergency care is significantly impacted every time we treat a patient who is uninsured.

As a result, we urge Congress to ensure that all Americans have health care coverage. In general, we believe that all Americans should have health insurance coverage for a comprehensive package of benefits which should encourage healthy living and emphasize preventive medicine. In so doing, we believe that Americans will be encouraged to live healthier lives and thereby decrease their reliance on expensive and sometimes unnecessary medical care.

However, we further believe that all Americans should be covered for at least those services which are most critical to their needs. We understand from recent newspaper accounts that the President's health care plan may model its benefit package after



those offered by health maintenance organizations which are listed as part of the HMO Act. We support using the HMO benefits package, which includes ambulance services.

While we realize that there are many competing interests seeking to be included as a part of the standard benefits package, we strongly recommend that emergency medical services and medically necessary ambulance services be retained as services covered as a part of the standard benefits package. We believe that universal access to quality EMS care is not only something that the American public expects and deserves, but that it will actually result in overall cost savings.

The service we provide often means the difference between life and death. In fact, numerous studies have shown that early intervention by qualified paramedics significantly reduces morbidity rates. However, a fact which is less well known is that early intervention by emergency medical personnel also reduces the amount of long-term care required by the patient, thereby reducing costs. Recent studies have shown that patients in life-threatening emergencies who receive emergency medical care within 8 minutes have dramatically reduced morbidity and long-term costs.

We applaud the President and you, Mr. Chairman, and other members of the committee for your commitment to ensure that every American has access to quality medical care. The American Ambulance Association stands ready to assist the Congress in its efforts to put such a plan into place.

Thank you again for the chance to testify, Mr. Chairman. I have brought with me a copy of our association's position paper on health care reform, and I would request that it be submitted as part of your record. For your interest, our paper includes several ideas for cost saving measures which Congress could institute relatively easily within our industry.

I would be happy to answer any questions that you or your committee members might have. Thank you.

[An attachment to the prepared statement follows:]

## POLICY STATEMENT ON THE AMERICAN AMBULANCE INDUSTRY

prepared for the

AMERICAN AMBULANCE ASSOCIATION

1993

I. STATEMENT OF PURPOSE

This is a position paper written on behalf of the American Ambulance Association and is intended to fulfill several important purposes.

The main purpose of this paper is to identify the position of the American Ambulance Association with respect to health care reform.

This paper will also provide a brief historical perspective on the evolution of today's current Emergency Medical Services (EMS) industry, and additionally will attempt to present an overview of the distinguishing factors associated with this unique provider group.

This paper will also provide background on some very specific health care reform issues and attempt to show the potential impact of certain reform measures on the EMS industry.

Finally, this paper will suggest some specific ways to cut waste in the health care delivery system based on the perspective of members of the American Ambulance Association.

II. BACKGROUND ON THE AMERICAN AMBULANCE ASSOCIATION AND THE ROLE OF EMS PROVIDERSA. CAREGIVERS, HEALTH CARE PROVIDERS AND PUBLIC SAFETY SERVICES

When tragedy strikes, Americans expect high quality ambulance and emergency medical services. Television shows such as "Rescue 911" reinforce the expectation that these services should be readily available, within minutes of every call, in communities throughout our Nation. This expectation must not only be met for the continued protection of human life but also because quality care at this point of intervention significantly affects the control of costs associated with hospitalization, rehabilitation, long-term care and related physician and other health care costs.

The American Ambulance Association is the national trade association representing businesses who provide fee-for-service ground ambulance transportation. Our association primarily represents all forms of private providers, but also includes public utility models, volunteer ambulance corps, hospital-based ambulance providers and government-owned and operated services.

Every time you pick up a newspaper and read about a manmade or natural disaster, you can find us. When the earthquakes struck San Francisco and Oakland, we were there. When the riots erupted in Los Angeles, we were there. When Hurricanes Hugo and Andrew devastated our coastline, we were there. When the Blizzard of 1993 blanketed the entire East Coast with ferocious storms, we were there. And most recently, when terrorists bombed and disabled the World Trade Center in New York City, again we were there, providing essential care for those in need.

When caring for people is needed, whether during periods of disaster, or personal injury, or when making a patient comfortable during a simple transport between health care facilities, we are there.

### B. EMERGENCY MEDICAL SERVICES MAKE A DIFFERENCE

For many Americans, their first experience with the health care delivery system may very well start with the arrival of EMS personnel. How well the EMS system performs for them will impact directly on their prognosis, and significantly affect the ultimate cost of their health care. Since the modern-day EMS industry began to flourish in the 1960's and 70's, using the lessons learned on the battlefields of Korea and Vietnam, it has become more sophisticated and better able to provide quality patient care and medical intervention.

Advances in technology coupled with the continuing improvement of skills of the Emergency Medical Technician (EMT) and Paramedic have literally changed the face of emergency medical care. It is clear then that the increased availability of highly qualified EMS providers is an essential factor in saving lives, reducing human suffering, reversing life-threatening situations, and/or reducing the severity of life-debilitating injuries or periods of recovery.

These advances have yielded tangible results. A recent study has shown that people have a better chance of survival and require less long-term care if EMS personnel are on the scene of a life threatening emergency within eight minutes.

### C. DISTINGUISHING FACTORS OF THE AMBULANCE AND EMS SYSTEM

Ambulance and Emergency Medical Services have maintained a proud heritage in service to America's communities for many years. Today these vital services can be found almost anywhere in the United States. Although there exists some generally accepted standards - in training, vehicles, equipment and levels of services (e.g. Basic Life Support and Advanced Life Support) - the U.S. has no single method of delivery or standard of care for EMS. For the most part, political considerations, degree of regulatory control, local market conditions, local medical standards, and economic factors set the framework for how EMS is established throughout our Nation's communities.

In general, there are four types of ambulance providers: (1) volunteers; (2) government-owned and operated services; (3) privately-owned and operated services; and (4) hospital-based services. Depending on the community, ambulance services could be provided by any one or all of these provider groups.

Financially speaking, each provider group is financed differently, depending upon the design of each individual system. For example, volunteers often receive financial support in the form of vehicles, stations, fuel, etc. from their community, in addition to receiving public donations. Government-owned and operated services are generally supported through local taxes. Hospital services are in many cases supported in part or in whole through hospital reimbursement structures, while privately-owned ambulance organizations rely mostly on reimbursement from patients or their third party insurance sources.

Operationally speaking, ambulance providers are also categorized by the type and level of services. For example; some organizations only provide emergency or 9-1-1 services while others only provide ambulance services to medical facilities for non-emergency, but medically necessary, transportation. Some providers are licensed at a Basic Life Support (BLS) level, while others provide the more sophisticated level of Advanced Life Support (ALS) services. Furthermore, based upon the needs or desires of a specific community, it is not unusual to have many competing providers operating within a single locality or conversely having only one provider designated to serve an entire community.



In contrast to other health care services, the ambulance industry is highly regulated by a variety of different entities at the federal, state, city, county and local levels. These regulatory bodies control the industry through forms of rate regulation - which set community standards for maximum rates - licensing requirements, response time criteria, equipment and supplies standards, training standards and the number and type of personnel (e.g. Emergency Medical Technicians or Paramedics).

Another distinction that is exclusively unique to the ambulance industry is that our services are activated by a phone call rather than the physical presence of a patient, and our services are rendered on a perceived need rather than on a diagnosis. Of all health care providers, our industry has the least control over the management of our services, with regard to access and ability to pay.

### III. HEALTH CARE REFORM ISSUES

It is the intention of the American Ambulance Association to bring forth ideas that will improve the quality of ambulance and emergency medical services provided to all Americans while at the same time controlling costs. Following are the positions of the Association regarding the general components of health care reform.

#### A. ACCESS

The American Ambulance Association strongly believes that every American should be able to obtain basic health insurance. The Association further recommends that all insurers be required to offer, as a basic benefit, the coverage of emergency medical services and medically necessary ambulance transportation.

Not only is this service one that all those in need should get, it is a service which the American people expect when they encounter a medical emergency. Also, quality ambulance service or pre-hospital care can have a dramatic impact on reducing morbidity and mortality thus saving dollars in the form of fewer in-hospital days, less of a need for rehabilitation, etc. This makes quality ambulance and pre-hospital care one of the best preventive health care values for the money.

Since improving people's health while saving money is the goal of health care reform, it makes sense that these essential services be part of a standard benefit package.

#### B. QUALITY

Currently, quality control exists in the EMS industry because EMS providers are required to meet a variety of federal, state, county, and local regulations. However, in the early 1980's, the American Ambulance Association initiated action to improve quality standards even beyond that which is required by government regulations by forming a Committee to establish standards that would lead to the formation of an independent accreditation body, similar to the Joint Commission on Accreditation of Healthcare Organizations (J.C.A.H.O.). In the late 1980's the project of formulating standards was completed and an independent Commission on the Accreditation of Ambulance Services, known as C.A.A.S., was born. In February of 1993, C.A.A.S. announced the first group of ambulance organizations to obtain national accreditation.

As a long-term goal, we recommend that all companies be accredited as a requirement for participation in any proposed health care system. Such accreditation standards would have to be phased in over a period of time to give all providers the opportunity to meet these new standards.



In the short term, however, the Association recommends that all ambulance providers meet the certification and licensing standards imposed by state, county and local regulatory agencies as a minimum requirement for participation in any proposed health care system.

#### C. COST

The American Ambulance Association strongly supports efforts to rein in skyrocketing costs in the health care industry. Our members provide quality, high-performance health care at a responsible cost. We are able to combine these elements because we operate in a competitive environment. As a result, we have faith that competition coupled with quality standards is the most effective way to bring quality health care to the greatest number of Americans at a reasonable cost. We recommend that what has worked in our industry be effectively applied throughout the rest of the health care industry.

To demonstrate our commitment to controlling costs, we have proposed several cost-saving measures which can be applied to our industry as well as to others and we encourage their adoption as part of overall health care reform. (See TAB 5, "COST SAVING SUGGESTIONS")

#### D. NATIONAL HEALTH BOARD

The American Ambulance Association recommends the formation of a broad-based independent national health board, which would be granted a full array of authority to structure on-going health care reform to meet both quality and cost containment goals. We support this concept on the basis that our industry would have appropriate and equitable participation. We further recommend that a specific subcommittee to the board be formulated, which would bring together leaders in related health care fields such as: ambulance and emergency medical service organizations, hospitals, physicians, etc.

#### E. MALPRACTICE REFORM

The American Ambulance Association strongly supports malpractice reform and believes that such reform should center on reducing exposure to frivolous lawsuits. Further we recommend malpractice reform that would extend to ambulance and emergency medical service providers universal "Good Samaritan" status that utilizes a gross negligence standard as a means of evaluating medical care provided. Since much of the service rendered by our industry is emergency in nature and occurs in uncontrolled settings, the need for protection from lawsuits is essential if time-sensitive quality treatment and transportation by EMS providers is to be encouraged.

#### F. ADMINISTRATIVE SIMPLIFICATION

The American Ambulance Association strongly supports administrative simplification and believes that, with respect to our industry, such reform will yield tremendous savings.

The American Ambulance Association recommends that all third party insurers, state Medicaid programs and Medicare be mandated to universally adopt the same claim forms and/or electronic formats, for the submission of ambulance and emergency medical service claims. Further we recommend that the coding and lists of allowable services be made uniform. In concert with these recommendations, we recommend that all third party payors be required to make payments directly to the providers of services. Such a policy would reduce the high cost of collection services and associated bad debts, and thereby produce savings.

#### IV. SPECIFIC ISSUES OF THE AMERICAN AMBULANCE ASSOCIATION

Because of the unique characteristics of the ambulance industry, the American Ambulance Association wishes to point out a few areas where certain reform measures currently under discussion such as freezes on levels of reimbursement or implementation of national fee schedules might have adverse consequences for the industry, seriously impacting its ability to continue to offer cost-effective high-quality services to the public.

##### A. REIMBURSEMENT REFORM

The ambulance and emergency medical services industry already has some elements of cost control imposed upon them. As stated earlier, many areas of the country have government agencies which regulate what ambulance providers can charge for their services. In an effort to further control federal health care dollars, Medicare, in 1985, imposed the Inflation Indexed Charge (IIC) as an additional factor under Medicare's method of reimbursement called "Reasonable Charge Methodology". Reasonable Charge Methodology means Medicare pays the lowest of the actual (submitted charge), the prevailing (what is charged by at least 75% of the providers in a locality), the customary (the organization's usual charge), or the IIC (the lowest of all of the screens from the prior year plus an inflation adjustment factor.)

The IIC holds levels of reimbursement to 1983 charge data plus annual inflation adjustments. However, these adjustments often have no relationship to the costs associated with our industry, or to a particular state or local region.

Although the IIC has had an impact in controlling Medicare costs, it has only caused providers to more aggressively cost shift. The reason for more aggressive cost shifting is that the IIC does not permit Medicare payments to rise in proportion to industry-specific inflationary costs. Thus, budget deficits are made up by dramatically increasing customary fees, which are then passed on to commercial insurers and patients. More recently, because the IIC is not industry-oriented, the gap between what Medicare pays and what is necessary to cover costs has widened so much it has caused some providers to refuse to accept assignment from Medicare. If this method of cost control is permitted to continue, without reform, quality in patient care and service will deteriorate and cost shifting will continue.

The American Ambulance Association therefore recommends the adoption of industry-specific reasonable charge methodology, which would be applied to all providers by type and used by all insurers, including Medicare and Medicaid, as further outlined below:

- Customary and Prevailing Charge Update: Update to the most current year customary and prevailing charge data of all ambulance providers. By recalculating this data, the levels of reimbursement will more accurately reflect current costs. Reasonable charges would be determined by using this updated charge data and the IIC would then be applied in subsequent years to restrict costs.
- Separate Charge Data by Provider Type: Separate customary and prevailing charge data based on the four provider types -- privately-owned and operated (for-profit/non-profit), hospital-based, volunteer, and government-owned and operated. This is necessary since public entities or government-owned and operated services are tax subsidized and should not be reimbursed at the same level as private providers who do not have the ability to tax or to cover expenses from the general

funds of the public. Similarly, volunteer and hospital-based services have costs different from private providers. If separate customary and prevailing screens are established, these inequities would no longer exist and reasonable charge determinations would more accurately reflect the respective costs of each group.

- **Modify Inflation Indexed Charge:** Modify the IIC so that it is both industry-specific oriented and adjustable to regional cost differences.

#### B. FEE SCHEDULE

The American Ambulance Association strongly recommends against placing ambulance providers under a fee schedule. Currently, ambulance providers are not reimbursed by Medicare under a fee schedule due to the differences in regulations at the state, county or local level. The different types of regulations involve rate regulation (e.g., rates set by the local agency based on an analysis of cost), response time mandates, personnel requirements (e.g., Paramedics vs. Emergency Medical Technicians and the number of each required in each vehicle), the training of the crew, the level of ambulance service (e.g. Advanced Life Support or Basic Life Support), etc. These regulations will differ state to state, county to county, and even from city to city within the same county. Expenses which are directly tied to these regulations vary greatly. As a result, putting ambulances on a fee schedule would prove disastrous for the system, and nearly impossible to administer.

#### V. COST SAVING SUGGESTIONS

In an effort to point out some changes which could be implemented immediately which would both improve the current reimbursement system and save money, the American Ambulance Association offers the following suggestions. These changes may also be relevant to any new proposed reimbursement system.

##### A. COVERED DESTINATIONS

When a patient requires medical attention, medically necessary ambulance transportation should be covered to the nearest appropriate facility, such as a free-standing emergency center - not necessarily the nearest hospital as is currently required. In other words, ambulance personnel should have the ability to transport a patient to the facility that is most appropriate for the patient based on the patient's condition. Further, transportation to the most appropriate facility should be covered for reimbursement purposes. Currently ambulance providers are only reimbursed if the destination is a hospital. This requirement puts an unnecessary strain on emergency room staff and costs the patient and the system thousands more in medical bills.

##### B. SIMPLIFICATION OF CLAIMS PROCESSING

Currently, for billing purposes, diagnosis codes must be used when submissions for reimbursement are made. This causes many problems for ambulance and EMS personnel because we do not make diagnoses. We respond based on a patient's condition. Therefore, the American Ambulance Association strongly recommends that codes for conditions (rather than diagnosis codes) be adopted for billing purposes.

##### C. CROSSOVER PATIENTS

For crossover patients (patients with Medicare and Medicaid), Part B providers must first bill Medicare and get a denial in order to bill Medicaid, even though they know the service is not covered by Medicare. Thus, many claims



are billed to Medicare just to get a denial. The American Ambulance Association recommends that a code or modifier be implemented that allows Part B providers to bill Medicaid directly. The code would, in effect, state "I have not billed Medicare as the service is not a Medicare-covered service."

#### D. MEDICARE SECONDARY PAYOR

Medicare wants providers to bill primary insurance when it exists. Part B providers want to bill the primary as well. However, the provider frequently is not aware of a primary insurer since the patients often do not disclose it either due to the emergency situation, condition of the patient or their confusion as to the order of the primary, secondary or supplementary. The AAA recommends that all Part B providers be able to have access to the same database used by Medicare Carriers to determine the primary insurance company. Access would be limited to patient name, HIC (or I.D.) number and the insurance information.

#### E. MEDICARE CARRIERS

Medicare Part B claims are paid by local Part B Carriers, Travelers (for Railroad Retirees) and the United Mine Workers Trust Funds (for UMWA). The American Ambulance Association recommends that separate Carriers be eliminated based on the employment of the beneficiary. These claims could easily be merged into the workloads of existing local Carriers so that a provider would send all Medicare claims to one carrier.

#### F. CLAIM RECONSIDERATION

Often one common issue will involve many claims. Currently, providers must submit each claim separately for reconsideration. One ambulance company challenging the rate paid for a procedure code had to submit over 2,200 separate claims for reconsideration and received separate denials in separate envelopes for each. The claim by claim reconsideration process is a wasteful administrative expense. Further, it ties up Carrier personnel on meaningless administrative functions. The reconsideration process is technically required, but is otherwise a waste of money since certain questions of law, reasonableness of reimbursement amounts, etc., cannot be decided at the reconsideration level.

The AAA recommends:

- (1) Permit one reconsideration (e.g. a cover letter with an attached listing of claims at issue) rather than the current requirement of a claim by claim review.
- (2) Permit one denial of the reconsideration cover letter noted above, rather than individual letters and/or EOMB's.
- (3) Permit providers to waive the reconsideration stage and go right to a Fair Hearing.
- (4) Permit providers and Carriers to stipulate to certain reconsiderations (e.g., that if an issue were reviewed for the claims on the list, that the reconsiderations would be denied), thereby allowing the provider to go to the Fair Hearing level saving all parties the administrative expenses of the reconsideration.

#### G. UNNECESSARY REGULATIONS

Health care costs could be reduced if well-meaning but impractical regulations were eliminated. For example, ambulance providers are considered to be within the requirements of the Clinical Laboratory Improvement Act, even though they: (a) are not laboratories; (b) do not bill for any laboratory tests; and (c) do not conduct any



laboratory tests other than the simple dextrose-stix. Yet, ambulance providers now have to file forms, pay an application fee and apply to be exempt from CLIA. Unfortunately, agencies or task forces within agencies pass regulations intended for one industry, but which often impact others.

The American Ambulance Association recommends the establishment of a panel or "ombudsman" within the Federal Government where trade associations, particularly in the health care field, can provide their reasons for exemption from regulations that appear to serve no purpose for that industry.

#### VI. AMERICAN AMBULANCE ASSOCIATION CONTACTS

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Mr. ANDREWS. Thank you, Mr. Moffitt.  
Dr. Finn.

**STATEMENT OF SUSAN CALVERT FINN, PH.D., R.D.,  
PRESIDENT, AMERICAN DIETETIC ASSOCIATION**

Ms. FINN. Good afternoon, Mr. Chairman and members of the subcommittee. I would ask, Mr. Chairman, that my written statement be included in the record.

Thank you for this opportunity to testify today. I am Dr. Susan Finn, president of the American Dietetic Association. The American Dietetic Association is a 63,000-member organization of nutrition professionals. Registered dietitians are extensively educated and trained in the scientific knowledge of therapeutic nutrition and its application in disease prevention and treatment.

Nutritional therapies include the evaluation of a patient's clinical chemistries, taking anthropometric measurements, reviewing dietary intake for such things as nutrient/drug interactions, and developing treatment plans.

These services are provided in hospitals, nursing homes, doctors' offices, and health maintenance organizations and in home health agencies.

Mr. Chairman, if I can leave one message with you today on behalf of our members, it is that the scientific knowledge of nutrition has advanced so rapidly and the correlation of nutrition therapies with the treatment and prevention of disease is now indisputable. Yet nutrition therapies and services are not built into our health care system today.

Nutrition services must be covered as a specialized service in three areas: number one, in acute care as part of medical treatment of such diseases as cancer, heart disease, stroke, diabetes, and AIDS; number two, in caring for vulnerable populations, such as the elderly and preschool children; and, number three, in providing preventive care for the entire population.

Mr. Chairman, one of the most frequently asked questions about adding benefits to the standard package is: What will they cost? I am here today to tell the subcommittee that the coverage of nutrition diagnosis and nutrition treatment saves health care dollars.

The fact is that nutrition therapies provided under medical supervision are integral to disease prevention, treatment, and recovery. Between one-quarter to one-half of hospitalized patients are malnourished, which means that they have inadequate nutrient and calorie intakes and impaired nutritional status.

Malnourished patients have two to three times more complications than well-nourished patients, resulting in hospital stays that are, on an average, 5 days longer and \$2,500 to \$5,000 more costly for each patient stay.

These excessive costs would be avoided if professionally delivered nutrition services such as the assessment of nutrient intake and the design of nutrition treatments were provided. Dietitians control costs by assuring judicious use of high technological nutrition therapies, including parenteral and enteral nutrition.

Let me give you just a couple of examples of the many conditions and situations that dietitians see every day.

A 45-year-old AIDS patient with diarrhea and weight loss received nutrition treatment which cost \$8,000 and prevented a hospital stay that would have cost \$26,000. The dietician established in-home intravenous nutritional treatment after careful screening and assessment. This treatment resulted in weight gain, improved gastrointestinal symptoms, and the maintenance of hydration and electrolyte imbalance.

Here is another example: We know that heart disease is the number one killer in America and that it is directly linked to diet. The savings from a nutrition treatment in this area are tremendous.

As an example, a registered dietician was able to save over \$19,000 in cholesterol medication costs for a 43-year-old patient by developing an individualized nutrition plan that lowered his serum cholesterol from 280 to 190.

Despite the overwhelming evidence that professionally delivered nutrition services results in more cost-effective and higher quality care, registered dietitians supply these services to only a portion of the many people who need them. The reason? The reason is the current approach to accounting and reimbursing nutrition services discourages their use.

Health facilities account for and bill registered dietician services within the general room and board component of the health care bill, rather than as therapeutic treatment ordered by the physician. This means that screening, assessment, and counseling components of nutrition services are not considered part of medical treatment.

Now, given the role that all components of therapeutic nutrition plays, they are all and must be classified as covered medical services, and they all must be identified as a component of treatment costs.

Mr. Chairman, nutrition services are good medicine, and they are good policy. There are an overwhelming number of studies that show nutrition therapies result in lower health care costs, and if I can, Mr. Chairman, I would like to submit several of these studies with my written testimony.

I can't think of more important criteria for inclusion in the standard benefits package, except perhaps that well-nourished people tend to live healthier, happier, and longer lives.

My written testimony, Mr. Chairman, provides more details on these points. Thank you again on behalf of the American Dietetic Association for the opportunity to present our views to you today, and we look forward to working with you in the months ahead to work on this important problem that affects the health of all Americans.

[The prepared statement follows:]





## THE AMERICAN DIETETIC ASSOCIATION

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### Chairman Stark and Distinguished Members of the Subcommittee:

Thank you for the opportunity to testify before your Subcommittee today. I am Dr. Susan Calvert Finn, President of The American Dietetic Association.

The American Dietetic Association is the largest group of food and nutrition professionals in the world. As the advocate of the profession, The American Dietetic Association serves the public by promoting optimal nutrition, health, and well-being. The Association has 63,500 members, most of whom are Registered Dietitians.

Registered Dietitians must meet extensive educational requirements with an emphasis on physiology, chemistry, microbiology, and the scientific application of nutrition theory. In addition, they must complete an internship or other qualified experience in which they utilize their unique skills to assess individuals and determine the most appropriate nutrition treatment that will prevent additional complications or will facilitate recovery. After completing the education and experience requirements, they must pass a national examination.

Registered Dietitians are a critical part of the health care team in hospitals, nursing homes, physician's offices, clinics, health maintenance organizations, and home health agencies. They ensure that the patient is in optimum nutritional status to utilize other therapies most effectively. Only the Registered Dietitian is able to provide these services.

The American Dietetic Association (ADA) commends your efforts to address the issues that arise in defining a standard health benefits package. ADA believes that a standard health benefits package of comprehensive health services should be a part of a new health care system. Mr. Chairman, if I can leave one message with you today on behalf of our members, it is that therapeutic nutrition services, delivered by Registered Dietitians, must be a part of the standard health benefits package to ensure the highest quality and most cost-effective care. Specifically, nutrition services must be covered as a specialized service, like physical or occupational therapy is currently covered, when medically appropriate for inpatient, outpatient and in-home treatment. We would advise that the standard benefit package also include preventive nutrition services for vulnerable populations such as children and the elderly.

The fact is that nutrition services provided by a Registered Dietitian, under physician orders, are integral to disease prevention, treatment, and recovery, and are necessary to maintain quality and to achieve cost savings. Today I will focus my comments on nutrition services, in which area I have practiced for 25-years, and on the cost-benefits of including nutrition services in a standard benefit package. I have based much of my testimony on ADA's legislative platform entitled "Economic Benefits of Nutrition Services" which is attached.

Nutrition services directly impact the patient's health or medical condition. Without adequate nutrition, human beings cannot survive, cannot heal, and cannot maintain good health. Appropriate nutrition is important to all stages of the life cycle: from prenatal care and infancy to the last years of life. The nutrition services of screening, assessment, and treatment are cost-effective for those at high risk for medical and nutritional problems, both in the prevention or delay of disease and its complications, or in the recovery stage.

Nutrition assessment is the evaluation of the nutrition needs of individuals based upon biochemical tests (e.g.; serum albumin, hemoglobin, urinary creatinine), anthropometric measures (e.g.; height, weight, skinfold thickness), physical examination, and dietary information (which includes diet-drug interactions). The Registered Dietitian uses his/her clinical judgment to determine the most appropriate nutrition treatment, which can include enteral and parenteral nutrition.

Nutrition treatment includes intervention and counseling on appropriate nutrition intake by integrating information from the nutrition assessment, nutrition theory, and information on food and other sources of nutrients to provide the patient with optimal nutrition for his/her condition. Nutrition treatment is provided as a part of the physician's overall care plan.

Mr. Chairman, one of the most frequently asked questions about adding benefits to the standard package is: What will they cost? I am here today to tell the Subcommittee that



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coverage of nutrition services can help save scarce health care dollars. Registered Dietitians have demonstrated they can save critical health care dollars when providing services in inpatient, outpatient, home care, and long-term care settings.

## **PREVENTION**

Nutrition services play an important role in the health of both sick and well individuals. Health promotion and disease prevention are key components of comprehensive health care. The goals of preventive care are to keep people healthy in their communities, to reduce the incidence and severity of preventable diseases, to improve health and quality of life, and to reduce total medical costs, particularly costs for medication, hospitalization, and extended care.

The 1988 *Surgeon General's Report on Nutrition and Health* states that eating and drinking habits contribute to 8 out of 10 of the leading causes of death including coronary heart disease, some types of cancer, stroke, diabetes mellitus, and atherosclerosis. The link between dietary fat and coronary heart disease is well established and now early studies appear to link fat intake to some cancers, specifically breast, colon, and prostate cancer. More than \$200 billion each year, or 1/4 of the total health care dollars, is spent for treatment of these diet related diseases. Despite overwhelming documentation that links diet to disease, the U.S. spends only 3% of its health care dollars on preventing disease.

We know that heart disease is the number one killer in America and that it is directly linked to diet. Nutrition services are appropriate for patients identified as being at high risk for cardiovascular disease, especially those who are overweight or have high serum cholesterol. Nutrition treatment can be used to decrease the use of cholesterol lowering medications and the risk of heart attacks. For every 1% cholesterol is decreased, there is a 2% decrease in risk of coronary heart disease. An example of the cost-effectiveness of nutrition treatment in decreasing serum cholesterol is a 43 year old man from Weymouth, Massachusetts who, after receiving individualized treatment from a Registered Dietitian, reduced his total serum cholesterol from 280 mg/dl to 191 mg/dl. This saved the use for a lifetime need of cholesterol lowering drugs which would have cost over \$19,000. The Registered Dietitian made an assessment and determined the treatment that was best suited for his particular lifestyle.

Without prevention, there would be a gap in health coverage. Nutrition services are the cornerstone of cost-effective prevention and must occur early in life to help drive down the spiraling cost of health care. More aggressive nutrition intervention early in life can have a major impact on disease later in life.

## **VULNERABLE POPULATIONS**

ADA is particularly concerned about vulnerable populations, especially those at each end of the age spectrum. Nutrition services for high risk pregnant women can lead to proper growth and development of the fetus and prevention of low-birth-weight infants and complications that cost our nation 3.5 to 7.5 billion dollars each year. No period in life is more important to good health than the months before birth. Early nutrition intervention can substantially change the course of events to improve pregnancy outcome. It is more cost-effective to provide nutrition services to a pregnant woman than to pay for the delivery and care of a low-birth-weight infant.

We all know how important nutrition is in the physical and mental development of infants and children. Nutrition assessment and treatment is especially important for those children with physical or developmental disabilities or those with a chronic medical condition caused by or associated with genetic/metabolic disorders, birth defects, prematurity, trauma, infection, or perinatal exposure to drugs. These children make up 10-15% of the pediatric population.

Nutrition related disease is a reality for all age groups. However, with older Americans, people often confuse the signs of malnutrition with the signs of aging. For instance, an older person who is dehydrated and malnourished may appear confused and disoriented, and this can be interpreted as senility rather than as a nutritional problem. Of Medicare beneficiaries, it is estimated that 24% are at nutritional risk. In addition, studies indicate that of the very elderly entering the hospital, 25% have moderate to severe malnutrition.

Many health care dollars are being spent on medical problems that are related to nutrition. Many of these dollars could be saved if nutrition services were included in comprehensive health care. An example of this is a study that shows older hospital patients with malnutrition have hospital charges double those of adequately nourished

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patients, partially because they stay an average of 5.6 days longer. Another study showed malnourished patients cost a hospital more money than the payment it receives based on the DRG system.

Nutrition status is often overlooked and ignored. I experienced this first hand several years ago when I saw my father nearly die from malnutrition.

My father was admitted to a hospital emergency room for urinary retention. He was catheterized and in doing so, his colon was accidentally perforated. He was then hospitalized.

The immediate belief of the medical staff was that he had a tumor in the bladder or prostate, although none was apparent. The trouble was just beginning. No one bothered to screen or assess my father for nutrition problems even though my father looked malnourished. He was six feet tall and due to my insistence, he was weighed. He weighed 115 pounds. He was apathetic, frail, and frankly, close to death. His appearance confirmed the view of the medical staff that my father had cancer.

Complications occurred and a temporary colostomy was performed. Upon my persistence, the dietetic staff became involved in my father's care. They determined that he was malnourished and started him on aggressive nutrition support. After several weeks of nutrition therapy by a Registered Dietitian, my father began to dramatically improve. He gained weight and became more alert and energetic. After five weeks of costly hospital care, he was discharged and received home care. His frail physical appearance was due to malnutrition; not cancer as the medical staff believed. Who knows how many times this sort of situation happens in hospitals around the country today? My father is now 78-years old and is doing fine.

#### ACUTE CARE

Nutrition therapy has been changing over the past decade and is much more complex than ever before. Although the role of nutrition services and the Registered Dietitian in acute care are beginning to be recognized as having an integral part in the recovery of the patient, too often nutrition is not thought of as an important medical matter, but as an administrative function included under room and board cost in hospitals and long-term care facilities or not at all in other settings. Nutrition services must be separately considered as a covered service.

Well-nourished individuals are more resistant to disease and are better able to tolerate other therapy and to recover from acute illness, surgical interventions, and trauma. Inadequate nutritional intake can precipitate disease or increase its severity. In other words, nutrition treatment can help the patient recover more quickly and decrease the number of days required in the hospital or the amount of care required. The following examples indicate the benefits of nutrition services in an acute care setting:

1. A Registered Dietitian at the Washington Hospital Center documented that she saved over \$5,300 with only a half hour of her time. She developed a care plan that included switching a patient to a different IV feeding that had less protein but adequate calories which resulted in decreasing the need for daily dialysis treatment to dialysis every other day.
2. Results from several controlled studies confirm direct benefits for patients and the hospital in terms of fewer complications and reduced length of stay when nutrition intervention is administered to patients in stress situations such as surgery and burns. Registered Dietitians make an assessment of the amount of calories, protein, vitamins, minerals, and other nutrients that are needed for healing to occur and then take actions that provide these nutrients in a manner tailored to each individual's medical condition.

Nutrition services play a key role in many diseases including diabetes, heart disease, renal disease, and AIDS. Studies and anecdotal information indicate that the inclusion of Registered Dietitians working with physicians can save money for patients, hospitals, nursing homes, HMOs, and home health agencies.

#### OUTPATIENT AND HOME CARE

As I said earlier, nutrition treatment and other health care services have changed over the past 10 years. More and more patients are being released from the hospital with medical conditions requiring therapeutic nutrition care. These patients, who are still under the care of their physician, must be assessed by a qualified professional who can find the

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most appropriate, cost-effective method of nutrition treatment. In these situations, we know that dietitians can improve patient outcome and prevent complications of disease which would require increased use of scarce health care dollars.

For instance, in patients with diabetes, Registered Dietitians can often help them obtain and maintain control of their diabetes with dietary changes. A dietitian in Boston documented that with individualized treatment (three short visits and four classes) a 45-year old male was able to go off insulin, which saves over \$8,000 in health care costs each year.

Another example is a 77-year old male with chronic renal failure who had four outpatient visits with a Registered Dietitian. The dietitian assessed lab values and dietary intake and from this she ascertained what nutrition treatment would be needed to maintain appropriate fluid, electrolyte, and nutrient balances. She adjusted the amount of fluid, carbohydrate, nitrogen, potassium, phosphate, and sulfate that he could tolerate. This resulted in improved renal function, reduced medications, and avoidance of dialysis which translates to a better quality of life. The dietitian's services cost \$92 and an estimated \$20,000 for just one year's cost of medication and dialysis was saved.

Many patients receive complicated medical and nutritional services in their homes. We find that costs of home health care can be reduced by early application of nutrition services for patients with acute and chronic disease. For example, a 45-year old AIDS patient with diarrhea and weight loss received six individualized visits from a dietitian who advised a IV nutrition treatment to prevent hospitalization. The dietitian assessed the patient's nutritional status and gastrointestinal tolerance and determined the best feeding that provided: relief for the gastrointestinal tract; adequate calories to meet the needs of the metabolic stress of the disease; increased protein intake to combat the breakdown of the lean body mass; and appropriate levels of vitamins and minerals needed to balance the increased metabolic activity of the disease. The outcome was weight gain, improved gastrointestinal symptoms, maintenance of hydration and electrolyte balance, and the avoidance of a hospital stay. It cost \$8,000 for the IV nutrition treatment but it avoided a \$26,000 hospital stay.

#### MANAGED CARE

Registered Dietitians currently play a role in managed care settings and are a part of the health care team that provides comprehensive care to its members. They provide therapeutic nutrition services for those diagnosed to be at nutritional risk and often are utilized to provide preventive health care to any member who wishes to participate.

Prevention is more than just keeping people well. It includes keeping people healthy in their communities, reducing the incidence and severity of preventable diseases, improving health and quality of life, and reducing total medical costs, particularly costs for medication, hospitalization, and extended care. It is much simpler and more cost-effective to lower a patient's cholesterol through dietary changes than to do open heart surgery.

#### SUMMARY

Despite the overwhelming evidence that professionally delivered nutrition services result in more cost effective and higher quality care, Registered Dietitians provide these services for only a portion of the patients who are malnourished. The reason: the current approach to accounting and reimbursing many parts of nutrition services discourages their use.

Acute and long-term-care health facilities account for and bill Registered Dietitian's services within the general room and board component of the health care bill rather than as therapeutic treatment ordered by the physician. This means that the assessment, and treatment component of nutrition services are not given priority and are not considered part of treatment. Given the role that all components of therapeutic nutrition services play, they all must be classified as a covered special service, like physical therapy, and identified as a component of treatment costs.

It is the position of The American Dietetic Association that a standard health benefits package be developed and that nutrition services be included. Nutrition services of assessment and treatment provided by Registered Dietitians are critical to the appropriate medical care of patients and in the end, save money.

## **Economic Benefits of Nutrition Services**

### **Health Care Reform Legislative Platform**

of

#### **The American Dietetic Association**

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**March 18, 1993**



*If you are among the two out of three Americans who do not smoke or drink excessively, your choice of diet can influence your long-term health prospects more than any other action you might take.*

*Eight out of the ten leading causes of death, including heart disease, strokes, some types of cancer, and diabetes, are related to diet and alcohol.*

*-The Surgeon General's Report on Nutrition and Health (1)*

*The American Dietetic Association, Association of the Faculties of Graduate Programs in Public Health Nutrition, Association of State and Territorial Public Health Nutrition Directors, and The Society for Nutrition Education (The Coalition) believe that quality health care must be available, accessible, and affordable to all Americans. Quality health care is defined to include nutrition services that are integral to meeting the preventive, therapeutic, and rehabilitative health care needs of all segments of the population. Nutrition services of screening, assessment, education, counseling, and treatment must be included in health care reform proposals. Nutrition services must be covered as a benefit in the basic benefits package currently being considered by the Administration. Coverage for nutrition services must be provided under Medicare and Medicaid, other public programs, and private and corporate insurance programs. These services must be provided by a Registered Dietitian or other qualified professionals who meet licensing and/or other standards prescribed by the Secretary in regulations.*

Any health care reform proposal must include nutrition services. These cost-effective services must be a component of the basic benefits package currently being considered by the Administration for the Medicare and Medicaid programs, other public programs, and private and corporate insurance programs. In addition, nutrition services must be maintained in all comprehensive federal, state, and local programs designed to improve the public's health.

This basic benefits package is fundamental to meeting minimum health care needs of all Americans. Nutrition services included in the basic benefits package are cost effective, especially for persons at risk for acute and/or chronic medical conditions. These services prevent the need for more costly medical or surgical treatments and reduce costly complications associated with disease progression. Nutrition services are an integral part of health care for those at nutrition risk in primary care, acute care, outpatient care, home care, and long-term care settings; in health care for mothers and children and for older Americans; and in preventive care.

Nutrition programs and services that promote health and prevent disease are fundamental to health care reform. These programs and services must foster personal and community responsibility for healthy behaviors and lifestyles, and be delivered in primary care, public health, and community settings. To maximize the benefit, these nutrition programs and services must be culturally appropriate and meet the needs of the vulnerable and frequently underserved segments of our population and be included in preventive care, maternal and child health care and in health care services for older Americans.

## Economic Benefits of Nutrition Services in Acute Care

*Nutrition services in acute care play a vital role in the recovery of the patient. The Coalition supports coverage and indirect reimbursement of nutrition services in the basic benefits package and under Medicare for inpatients. Nutrition services must be identified as separate and distinct from administrative services.*

Among hospitalized adults, excess costs for patients with malnutrition were \$5,575 for surgery patients and \$2,477 for medical patients (2).

Adequate nutrition is essential to reduced morbidity and mortality from acute and chronic disease. Well-nourished individuals are more resistant to disease and are better able to tolerate other therapy and to recover from acute illness, surgical interventions, and trauma.

Inadequate nutritional intake can precipitate disease or increase its severity. Early detection of nutrition-related problems and appropriate nutrition treatment are effective in preventing increased morbidity from many diseases. In other words, nutrition treatment can help the patient recover more quickly and decrease the number of days required in the hospital.

Nutrition services are currently included in the room and board charge that appears on an inpatient's bill. Medically necessary nutrition services in inpatient health care settings must be considered specialized care and be reimbursed separately, in a manner similar to other services (e.g., those of occupational and physical therapists).

This separate coverage is particularly important in light of the following points:

- An incidence of malnutrition of up to 50% of hospitalized patients (3)
- The high correlation between malnutrition and disease complications
- Advances in nutrition administered by vein or tube
- Evidence that nutrition intervention corrects malnutrition, prevents disease complications, and speeds rehabilitation
- Evidence that nutrition is critical to certain patients' progress (e.g., those with diabetes, pressure sores, and cardiovascular disease) following acute care.

Registered Dietitians control costs by assuring judicious use of costly high-tech nutritional therapies, including parenteral nutrition (nutrition by vein) (4). When parenteral nutrition is used properly, postoperative complications can be reduced by 38% (5). Parenteral nutrition administration and monitoring may cost as much as \$500 per hospital day. Substantial savings can be realized when enteral feeding (via tube in the gastrointestinal tract) is substituted for parenteral nutrition. Because nutrition in medical education remains in its infancy, it is the Registered Dietitian who has the expertise to make this determination in the acute care setting. A Registered Dietitian in Philadelphia who works with a managed health care company saved her firm \$60,000 by competent discharge planning and transitional feeding planning for one parenteral nutrition patient.

Registered Dietitians provide an essential role in assuring the most cost-effective provision of nutrition care. For example, there are more than 200 nutrient products on the market. Cost savings have been realized when Registered Dietitians manage hospital nutrient solution formularies. One dietitian saved a hospital \$40,000 annually by determining that one more expensive parenteral formula was not more therapeutically beneficial than the standard formula.

The American Dietetic Association has developed validated practice guidelines for specific disease states and conditions including kidney disease, liver disease, lung dysfunction, burns, diabetes, AIDS, cancer, short bowel syndrome, bone marrow transplantation, pediatric care, solid organ transplantation, parenteral and enteral nutrition treatment, pediatric nutrition care, and older adult nutrition care. In developing and using practice guidelines, Registered Dietitians aim to link standardized practice to positive outcomes, thereby insuring efficiency and effectiveness in the delivery of care. For example, positive outcomes of nutrition intervention in burn care include increased survival rates, decreased length of hospital stay, decreased length of stay in intensive care units, decreased complications, and decreased negative weight changes (6).

Several factors have contributed to an increase in the demand for nutrition services: the aging of the population, the AIDS epidemic, the higher acuity level of hospitalized patients, and the coexistence of malnutrition with chronic diseases.

In sum, The Coalition recommends separate reimbursement for nutrition services in acute care settings as a clinically effective and cost effective component of health care reform.

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## Economic Benefits of Nutrition Services in Outpatient Care

*Appropriate nutrition services are a cost-effective way to keep people healthy and save scarce health care dollars. The Coalition supports coverage and reimbursement for nutrition assessment and treatment in the basic benefits package and in Medicare Part B, Medicaid, and other plans for high-risk patients. The Coalition supports outpatient nutrition services provided to patients under the care of a physician with development of a plan prescribing the type, amount, and duration of nutrition services.*

Since the prospective payment system has decreased the length of hospital stays, many patients go home requiring further care. However, nutrition treatment--previously provided to inpatients who need to follow special diets after discharge--may not be reimbursed by Medicare as an outpatient service. Because these critical follow-up costs may not be paid by Medicare or other sources, many patients do not follow through with the necessary nutrition treatment.

For example, when patients with diabetes are released from the hospital, maintenance of a diet plan can be critical to the stabilization of the health of the patient and prevention of re-hospitalization. Diabetes requires daily management--including balancing of food, exercise, and (in some cases) medication--to control blood sugar, maintain appropriate weight, and prevent or delay serious, permanent damage (blindness, amputation, or death). Appropriate nutrition services are a clinically effective way to treat people with diabetes. The most cost-effective use of nutrition services is to keep patients healthy by giving them the training they need to maintain a healthy lifestyle.

Medically necessary nutrition services in outpatient health care settings must be considered specialized care and be reimbursed in a manner similar to care provided by occupational and physical therapists.



## Economic Benefits of Nutrition Services in Home Care

*Costs of home health care can be reduced by early application of nutrition services for nutrition-related diagnosis. Patients whose care plan includes nutrition treatment and patients on enteral and parenteral nutrition therapy must be assessed and treated in line with the care plan developed with a physician. The Coalition supports coverage and indirect reimbursement of nutrition assessment and treatment as part of the basic benefits package and under the Medicare program.*

Since the prospective payment system has decreased the length of hospital stays, many patients are discharged requiring further nutrition treatment. Many of these patients, who cannot be placed in a nursing facility or make periodic trips to the doctor's office or clinic, receive health care at home. Nutrition treatment that was previously provided to inpatients who have serious and complex nutrition treatment needs is not currently provided as a home health care benefit.

Many patients are being discharged still requiring nutrition therapy by vein (parenteral) or tube feeding (enteral) in the home. While home enteral and parenteral nutrition can potentially save costs associated with expensive hospitalization, the home care industry has not been able to respond adequately to the care needs of home parenteral and enteral nutrition patients due to lack of reimbursement for nutrition treatment. Excessive costs for these therapies can be reduced by early nutrition assessment and appropriate nutrition treatment in home care settings. Home parenteral or enteral nutrition treatment requires regular follow-up and monitoring by Registered Dietitians in order to prevent hospital readmission due to complications.

Provision of nutrition services in the home health care setting is a cost-effective way to treat people with diabetes and other chronic diseases such as kidney failure and AIDS. For example, patients with diabetes are a large population group for which nutrition treatment can be critical to the stabilization of health and the prevention of re-hospitalization. Diabetes management requires daily attention to food intake, exercise, and medication to control blood glucose and prevent or delay disease complications.

Currently, nutrition services are included in administrative costs and are not separately billable. Home health agencies with limited administrative funds are often forced to use employees who are not trained to assess the nutritional status of patients. This often leads to complications for the patient, more costly care, and increased use of higher cost options for feeding that are Medicare reimbursable. Dollars can be saved by using the appropriate health professional.

Medically necessary nutrition services in home health care must be considered specialized care and be reimbursed in a manner similar to care provided by occupational and physical therapists.

## Economic Benefits of Nutrition Services in Long-Term Care

*Nutrition services provided in long-term care improve the quality of life, slow the rate of physical deterioration, and prevent further costly hospitalization or the need for a higher level of care. The Coalition supports coverage and indirect reimbursement of nutrition assessment and treatment in long-term care facilities as part of the basic benefits package and under the Medicare program.*

It is often assumed that the daily provision of three nutritious meals meets the nutritional needs of nursing home residents. In reality, individualized nutrition services are necessary since the number of residents requiring a higher level of acute care is increasing.

For a variety of psychosocial, economic, and medical reasons, elderly individuals in nursing homes are particularly prone to suffer from protein-calorie malnutrition as well as certain micronutrient deficiencies. Appropriate nutrition services can improve the quality of life, slow the rate of physical deterioration, and prevent costly hospitalization or the need for a higher level of skilled care.

Decubitus ulcers (pressure sores) can be a significant problem in nursing home residents. It is estimated that the average pressure sore costs \$15,000 to treat and frequently involves surgical treatment (7). Conditions such as anemia, hyperglycemia, dehydration, food-drug interaction, and vitamin/mineral deficiencies also are indicators of patients at risk for pressure sore development. Nutrition treatment delivered to residents with decubitus ulcers can speed the healing process and optimal nutrition care can help prevent them from re-occurring. The development of pressure sores correlates directly with the incidence of protein-calorie malnutrition.

Many residents are on enteral or parenteral feedings that require the expertise of a Registered Dietitian to determine the optimum balance of nutrients and fluid. Consultation by a Registered Dietitian in these situations can create significant savings for the facility. For example, a skilled nursing facility saved \$3,000 per month on one patient after a Registered Dietitian conducted a nutrition assessment and evaluation that resulted in improved patient acceptance of meals and decreased use of a costly supplement.

Federal requirements mandate that nursing facilities employ a qualified dietitian on a full-time, part-time, or consultant basis. Nutrition services are included as a part of the facility's administrative costs, rather than as a separate charge. Financial pressures in the health care delivery system often force facilities to utilize a consultant dietitian for a minimum number of hours per month, and then use less qualified personnel to cover the rest of the time. The increase in acuity level of the residents combined with the few hours the dietitian has in the facility make it more likely now that the nutritional needs of residents are not met. This, in turn, can lead to increased complications and health care costs.

Therefore, The Coalition recommends coverage and indirect reimbursement for nutrition assessment and treatment in long-term care facilities.

## Economic Benefits of Nutrition Services in Preventive Care

*Health promotion and disease prevention nutrition services and programs are necessary, cost-effective, and humanitarian measures for the prevention of, and delay in the progression toward disease. These services and programs must be universally available and offered in a variety of settings that are both traditional and innovative and foster personal responsibility for health behaviors and lifestyle. To maximize the benefit, nutrition services must be responsive to the individual's culture, learning capacity, life situation, and assure access to a nutritious diet. The coalition supports inclusion of nutrition services and programs in preventive care.*

The goals of preventive care are to keep people healthy in their communities, to reduce the incidence and severity of preventable diseases, to improve health and quality of life, and to reduce total medical costs, particularly costs for medication, hospitalization, and extended care.

A quality health care system must be available, accessible and affordable; contain mechanisms for monitoring and evaluating the public's health; assure that providers of nutrition care programs and services are qualified and have advanced training/education in nutrition; use clinical and applied research to improve health care practice; and maintain a comprehensive federal, state and local public health infrastructure to protect the community's health.

A quality health care system that is available, accessible, and affordable to all Americans must maintain a comprehensive federal, state, and local infrastructure. The infrastructure must be accountable for monitoring and evaluating the public's health; for assuring that providers of health care programs and services are qualified and have received advanced training/education in nutrition; for ensuring accessibility; for applying research to health care practice; and for coordinating the private and public delivery systems.

Eating habits can have a significant impact on the incidence and severity of many health disorders. It is clear that a direct relationship exists between nutrition risk factors and certain key diseases. Consider the following information released in the *Surgeon General's Report* in 1988 (1):

- **Coronary Heart Disease:** Despite the recent sharp decline in the death rate for coronary heart disease, more than 1.25 million heart attacks occur each year (two-thirds of them in men), and more than 500,000 people die each year as a result. It still accounts for the largest number of deaths in the United States. (Today, the cost of treatment is \$136 billion.)
- **Stroke:** In 1987, strokes occurred in about 500,000 people, resulting in nearly 150,000 deaths and long term disability for many more individuals. Approximately 2 million Americans suffer from stroke-related disabilities, at an estimated annual medical cost of more than \$11 billion.
- **High Blood Pressure:** High blood pressure is a major risk factor for both heart disease and stroke. Almost 58 million people, including 39 million who are under the age of 65, have high blood pressure. The occurrence of hypertension increases with age and, with the aging of the population, will become a more prevalent risk factor.
- **Cancer:** More than 475,000 people died of cancer in the United States in 1987, making it the second leading cause of death in this country. During the same period, more than 900,000 new cases of cancer occurred. In 1985, the costs of cancer were estimated to be \$22 billion for direct health care, \$9 billion in lost productivity due to treatment or disability, and \$41 billion in lost productivity due to premature mortality, for a total cost of \$72 billion.
- **Diabetes Mellitus:** Approximately 11 million Americans have diabetes, but almost half of them have not been diagnosed. In addition to the nearly 38,000 deaths in 1987 attributed directly to this condition, diabetes also contributes to an estimated 95,000 deaths per year from associated cardiovascular and kidney complications. Diabetes care costs \$20 billion per year.

- **Obesity:** In the U.S., obesity affects approximately 34 million adults ages 20 to 74 years, with the highest rates observed among the poor and minority groups. Obesity is a risk factor for coronary heart disease, high blood pressure, diabetes, and possibly some types of cancer, as well as for other chronic diseases.

The *Surgeon General's Report* goes on to state that eating and drinking habits contribute to heart disease, cancers, strokes, diabetes mellitus, obesity, and other killing diseases. The link between dietary fat and coronary heart disease is well established and now early studies appear to link fat intake to some cancers, specifically breast, colon, and prostate cancer.

In an aging population, a higher-fat, higher-calorie diet and less physical activity results in more obesity. The incidence of diabetes is increasing by 6% each year due to the change in the American lifestyle. Major risk factors include being over forty, overweight, member of a minority population, and having a blood-related family member with diabetes.

Nutrition programs and services, the cornerstone of treatment, can prevent, postpone, or mitigate the onset or progression of this disease and thus save scarce health care dollars.

Other benefits of nutrition services include prevention of obesity, coronary heart disease, some types of cancer, and other chronic diseases and their complications; improved recovery from illness; improved physical, social, and mental well-being; reduction in the need for medical services and recurrent hospitalizations due to malnutrition and related problems; maintenance of independent living; and costs averted for medical and institutional care, surgery, and drug therapy.

*Healthy People 2000* states profoundly that a nation's health is measured by more than its death rate. Good health comes from reducing unnecessary suffering, illness, and disability. It comes also from the citizens' improved quality of life and sense of well-being.

*Healthy People 2000* acknowledges that this nation has the means to prevent premature death and disability, and achieve the potential to live healthy lives in our own communities. We must now implement what we know about promoting health and preventing disease. Personal choices have a powerful influence over one's health prospects. The public must have the information and guidance necessary to make the wisest health choices, and nutrition plays a daily role in those choices.

Health promotion and disease prevention comprise our best opportunity to reduce the ever-increasing portion of our resources spent to treat preventable diseases and functional impairment.



## Economic Benefits of Nutrition Services in Maternal and Child Health

*Nutrition services for pregnant women can lead to the proper growth and development of the fetus and prevention of low birth weight infants and costly complications. Nutrition services are of critical importance to promote growth and development of infants and children, particularly those with developmental disabilities and chronic medical conditions. The Coalition supports family-centered nutrition services for all pregnant and breastfeeding women, infants, and children, and referral to established programs such as WIC and EPSDT. Pregnant women and children identified at risk, or with other complications or conditions, should receive preventive, therapeutic, and rehabilitative nutrition services.*

No period in life is more important to good health than the months before birth. The prenatal period can be the starting time for good health or it may be the beginning of a lifetime of illness and shortened life expectancy. Early nutrition intervention can substantially change the course of events to improve pregnancy outcome.

Each year in the United States, nearly 39,000 babies die before the age of one year. Low birth weight, which occurs in 7% of all births, is the greatest single hazard to infant health, costing the nation \$3.5 to \$7.5 billion each year. Medicaid pays almost \$19,000 per delivery of a low birth weight infant versus just \$ 3,500 per delivery of a normal weight infant (9). Poor nutrition is one of the major risk factors associated with low birth weight. Women who gain less than 21 pounds during pregnancy are more than twice as likely to deliver low birth weight infants than those who gain more. Nutrition is also vital to growth and development (including brain function development) of infants.

Assessment of nutritional status is an integral part of care at the beginning of pregnancy and periodically throughout pregnancy and breastfeeding to provide continuing monitoring and recommend appropriate intervention. Nutrition intervention is cost effective. In 1992, the U.S. General Accounting Office estimated that every \$1 spent on the Special Supplemental Food Program for Women, Infants, and Children (WIC) for pregnant women yields up to \$4.21 in Medicaid savings.

Specialized professional counseling on feeding should be provided to parents of low birth weight infants, other infants at high risk, and infants who require special formulas. Parents of children with special health care needs should also receive ongoing professional advice on appropriate diets and feeding methods. These include children with physical or developmental disabilities or those with a chronic medical condition caused by or associated with genetic/metabolic disorders, birth defects, prematurity, trauma, infection, or perinatal exposure to drugs. These children make up 10% to 15% of the pediatric population, but the costs of their care are disproportionately high (10).

Common nutrition problems among children--obesity, failure to thrive, undernutrition, iron deficiency, and dental caries--can have significant short-term and long-term consequences. Because eating habits are formed at an early age, the establishment of healthful eating patterns by children is particularly important. Children need good nutrition during childhood for adequate growth, development, and maintenance of health to decrease the cost of health care later in life.

Nutrition problems among adolescents include obesity, chronic dieting, eating disorders, hyperlipidemia, and dental caries. Fifteen to 27% of American children and adolescents are obese. The prevalence of obesity among children in the United States has increased significantly in the last two decades, and these children have an increased risk of adult obesity and its complications. The potential cost of these diseases could be prevented or significantly reduced with nutrition services for youth in primary care and other preventive health care settings.

## Economic Benefits of Nutrition Services for Older Americans

*Nutrition assessment and treatment are essential to decreasing morbidity, mortality, and attendant health care costs for vulnerable older Americans. The Coalition supports the Nutrition Screening Initiative recommendation for the inclusion of nutrition screening for this population. For those identified as being at nutrition risk, nutrition assessment and treatment must be covered and reimbursed by Medicare.*

Every day 5,000 people turn 65, and by the year 2030, 21% of the population will be over 65 (11). Advancing age brings increased dependency and added health care costs. Today, older Americans make up almost 12% of the population but account for 36% of health care costs and 30% or more of all hospital stays and drug prescriptions (11).

The impact of chronic health problems increases with age. Eighty-five percent of the older population has a chronic disease such as diabetes, hypertension, or cancer (12). Many of these diseases are diet related. Cardiovascular disease affects 50% of people over age 70 (13). Decline in nutritional status is not an inevitable part of the aging process; rather it is environmentally determined and frequently results from inattention to risk factors that can be improved by nutrition screening, assessment, education, counseling, and treatment.

Nutrition risk is the most important predictor of the total number of physician visits, visits to physicians in emergency rooms, and the occurrence of hospital episodes, according to a study by Wolinsky (14). Twenty-five percent of the "old" old are admitted to the hospital with moderate to severe malnutrition (15). In a study of older patients admitted to a hospital, those who were malnourished had actual hospital charges double that of those who were not malnourished, and their average length of stay was 5.6 days longer than patients without malnutrition (16). Proper nutrition assessment and treatment for those vulnerable older persons is essential in decreasing health care costs.

Once older persons have been identified as malnourished, services through public/private partnerships, such as home-delivered meals, should be made available to those who need them. Adequately nourished patients have decreased morbidity/mortality and fewer secondary medical complications and diseases. Their wounds heal faster, they have fewer infections, and their hospitalizations are shorter. These factors all reduce Medicare, Medicaid, and other third-party payer costs.

Nutrition services are critical because of their direct and immediate impact on the patient's health or medical condition. Provision of nutrition services decreases the costs of medical and institutional care, surgery, and drug therapy. Often elderly patients do not seek or follow up on recommended nutrition treatment because the cost of such services is not reimbursed to them.

## Overview of Costs to the American Public for Chronic Disease

Nutrition is a daily concern for all Americans. For the past 15 years Americans have become increasingly health conscious. However, disturbing statistics still exist as to the ability of Americans to understand and implement the array of messages they receive on nutrition and health.

- One third of all Americans are overweight (17).
- 1.5 million deaths in 1987 were diet-related (1).
- Seven percent (over 250,000) of U.S. infants are low birth weight, which contributes to the United States being ranked 23rd among industrialized countries in infant mortality (18).
- Fifteen to 27% of American children and adolescents are obese (19).

The U.S. spends \$2.3 billion *daily* on health care. In 1992, diet-related disease consumed a major portion of the \$838.5 billion dollar price tag for this nation's health costs (20).

- More than \$200 billion is spent for treatment of diet-related illness affecting 100 million Americans, including heart disease, high blood pressure, cancer, diabetes, and obesity (1).
- More than \$100 billion is spent for coronary heart disease in direct health care expenditures alone (8).
- More than \$72 billion is spent for cancer, including productivity losses (1).
- \$39.3 billion is spent on obesity (21).
- Between \$3.5 and \$7.5 billion is spent annually on low birth weight infants (8, 18).
- \$302 billion, or 36% of health care costs are spent for older Americans, while Medicare spent just \$102 billion on older Americans in fiscal year 1990 (22).
- \$20 billion is spent annually on diabetes treatment (23).

Another \$33 billion is spent annually on illusionary "quick fix" weight loss solutions by 65 million Americans (24).

The main challenge is no longer to determine what eating patterns to recommend to the public (although there is more to be learned), but how to inform and encourage an entire population to eat so as to improve its chance for a healthier life, thus driving down the cost of health care.

There is a clear need for comprehensive and coordinated action to improve America's diet and health, as documented in the following federally funded publications:

- *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* issued by the Department of Health and Human Services, September 1990
- *The Surgeon General's Report on Nutrition and Health* issued by the Department of Health and Human Services, Public Health Service, 1988
- *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions* issued by the U.S. Preventive Services Task Force, 1989
- *The Dietary Guidelines for Americans* issued by the Department of Agriculture and the Department of Health and Human Services, 3rd edition, 1990
- *Diet and Health* issued by the Institute of Medicine, National Research Council of the National Academy of Sciences, 1989.

In spite of the overwhelming documentation in these reports linking diet to disease, the U.S. spends only 3% of its health care dollars on preventing disease according to the Centers for Disease Control.

The nation can no longer afford to ignore its own reports and must reduce the high cost of disease in this country. Nutrition programs and services are the cornerstone of cost-effective prevention and must occur early in life to help drive down the spiraling cost of health care. More aggressive nutrition intervention early in life can have major impact on disease.



## Coalition Members

### *The American Dietetic Association*

The American Dietetic Association (ADA) is the nation's largest professional organization for dietitians, dietetic technicians, and other nutritionists. ADA is the advocate of the dietetic profession serving the public through promotion of optimal nutrition, health, and well being.

Founded in 1917, ADA membership has grown to more than 63,500 nutrition professionals. ADA members with extensive scientific backgrounds apply knowledge of food, nutrition, biochemistry, physiology, management, and behavioral and social sciences to promote health, prevent disease, and speed recovery from illness.

Registered Dietitians work in hospitals and other health care facilities, schools and universities, government and community agencies, and in business and industry. A growing number of Registered Dietitians are employed as consultants in nursing homes, physicians' offices, clinics, home health agencies, and restaurants; others are in private practice.

### *Association of the Faculties of Graduate Programs in Public Health Nutrition*

The Association of the Faculties of Graduate Programs in Public Health Nutrition is committed to the graduate education of qualified professionals to fulfill society's interest in assuring conditions in which people can be healthy. It is an association that is supportive, protective, and innovative in the promotion of optimal nutrition and health.

The purpose of the Association of the Faculties of Graduate Programs in Public Health Nutrition is to: establish and maintain standards of graduate education for public health nutritionists; facilitate communication regarding standards for graduate education between practitioners in the field, agencies, and organizations concerning preparation and employment of public health nutritionists; and provide a structure for addressing issues of common interest to member universities in matters related to public health practice, education, and research.

### *The Association of State and Territorial Public Health Nutrition Directors*

The Association of State and Territorial Public Health Nutrition Directors (ASTPHND) is a national organization composed of nutrition professionals who work in state health agencies and who are responsible for the agency's nutrition program. ASTPHND provides leadership to the state health agency perspective for national and state food and nutrition policy, programs, and services through communication, education, and research. The mission of ASTPHND is to promote achievement of optimal nutritional status for all sectors of the American population. ASTPHND was founded in 1952, and is an affiliate of the Association of State and Territorial Health Officials (ASTHO).

ASTPHND's members comprise the nutrition director or designee appointed by the chief official from each U.S. state, district, territory, or possession public health program, plus three additional members employed by the state health agency and charged with administrative and/or consultative responsibility for some aspect of the agency's nutrition program.

ASTPHND serves as a channel through which staff of public health nutrition programs of the states, territories, commonwealths, districts, and possessions of the United States may exchange information for the enrichment and improvement of public health nutrition programs. ASTPHND serves as an advisory body to ASTHO and other organizations on legislation and public policy related to food and nutrition issues and concerns.

*The Society for Nutrition Education*

The Society for Nutrition Education (SNE) is the professional association committed to linking nutrition, food, and education. The Society's mission is to enhance the ability of its members to help the public make informed food choices.

SNE's 2,100 members have leadership and decision-making positions in public health departments, departments of education, colleges and universities, government agencies, voluntary organizations, and other institutions recognized by the public as reliable sources of health and nutrition information. They are extension educators, food industry representatives, health educators, home economists, nutrition advocates, nutrition scientists, communications and public relations professionals, school food service personnel, and classroom teachers.

Founded in 1967, the Society maintains a highly effective public policy program. Working through coalitions, SNE provides a forum for discussion and debate of divergent interests and issues. The Society has a long and rich history of leadership in and advocacy for food safety and security. With a growing international membership, the Society is increasingly global in scope.

## Nutrition Services Terminology

**Nutrition Screening:** Nutrition screening is the process of discovering characteristics known to be associated with dietary or nutritional problems. Its purpose is to identify individuals who are at high risk of nutritional problems or who have unrecognized malnutrition. Intervention is facilitated when screening occurs. Screening is administered in community settings and health care facilities by a variety of personnel.

**Nutrition Assessment:** Nutrition assessment is the evaluation of the nutrition needs of individuals based upon appropriate biochemical, anthropometric, physical, and dietary data to determine nutrient needs and recommend appropriate nutrition intake including enteral and parenteral nutrition.

**Nutrition Treatment:** Nutrition treatment includes intervention and counseling of individuals on appropriate nutrition intake by integrating information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status. Nutrition therapy, a component of medical treatment, includes enteral and parenteral nutrition.

**Nutrition Care Plan:** A nutrition care plan is a written program of nutrition-related actions recommended to improve or protect health status. A nutrition care plan includes specific objectives, diet recommendations, feeding instructions, an educational plan, referrals if appropriate, and plans for follow-up.

**Nutrition Interventions:** Nutrition interventions are measures provided to prevent disease and treat conditions. The range of nutrition intervention services includes nutrition education and guidance; nutrition counseling; nutrition treatment (therapeutic dietary counseling); food supplements; food assistance and professional services; and equipment and supplies for enteral and parenteral nutrition services.

**Nutrition Education/Guidance:** Nutrition education and guidance is provided by qualified nutrition personnel. Nutrition education and guidance are processes used to increase awareness, knowledge, and skills for making informed decisions about food and eating practices, and to motivate the individual or groups of individuals to make healthful changes.

**Nutrition Counseling:** Nutrition counseling encompasses a group process or one-on-one process for addressing the individual's nutrition problems. The qualified nutrition personnel and the individual (or the caregiver) determine objectives for behavior change, strive to increase knowledge and skills, and address ways to establish or reinforce health behaviors that will improve, maintain, or restore health.

**Nutrition Risk:** Nutrition risk is a state or condition that contributes to a nutrition-related medical problem; examples include inadequate growth, vitamin/mineral deficiencies, diabetes, heart disease, and toxicities of alcohol, vitamins and minerals.

## Reimbursement Definitions

**Direct Reimbursement:** When a third party issues payment (for nutrition services) directly to the provider.

**Indirect Reimbursement:** When a third party issues payment (for nutrition services) to a facility or physician.

## Personnel Definitions

**Registered Dietitian (RD):** A person who has completed a minimum of a baccalaureate degree in dietetics or a related area at a regionally accredited college or university, has completed a supervised clinical experience, and has passed a national examination. More than 40% of Registered Dietitians also hold advanced degrees. To retain RD status, a dietitian must fulfill continuing education requirements to update and enhance knowledge and skills. The Registered Dietitian is qualified to perform nutrition screening, assessment, and treatment.

**Qualified Professional:** Personnel who are qualified to provide nutrition services include licensed professionals whose scope of practice and training include nutrition, and nutrition professionals with a baccalaureate or advanced degree from a U.S. regionally accredited college or university with a major in human nutrition, dietetics, public health nutrition, community nutrition, or nutrition education. These professionals have different levels of nutrition knowledge; therefore, responsibilities, duties, and qualifications should be described in standards prescribed by the Secretary in regulations and in requirements prescribed by state licensing boards.

**Dietetic Technician Registered (DTR):** A person who has completed a minimum of an associate degree in dietetics or a related area at a U.S. regionally accredited college or university, has completed a supervised clinical experience, and has passed a national examination. A DTR must fulfill continuing education requirements to update and enhance knowledge and skills. The DTR is qualified to perform nutrition screening and other nutrition services under the direction of a Registered Dietitian.

### **General Terms Related to Community Nutrition and to Individual and Group Nutrition Services**

**Family-Centered Care:** Family-centered care recognizes that the "family" (the individual's support system) is the constant in an individual's life, whereas the health service systems and personnel within systems change. Family-centered health care services are accessible, flexible, and responsive to needs identified by the family and to the family's culture. Family-centered care is a process that facilitates collaboration by providers and agencies at all levels of health care.

**Health Promotion:** Personal environmental or social interventions that facilitate behavioral changes to improve health, level of function, and sense of well-being.

**Public Health and Community Nutrition Programs -** Public health and community nutrition programs are nutrition interventions designed to maintain or improve the nutritional status and general health of the population through all stages of the lifecycle. Public health nutrition programs usually are implemented through the official public health agency with organized collaboration of other public and private organizations and agencies. Community nutrition services are those services that are delivered at the community level addressing the needs of individuals and families living in specific communities. The primary purpose of these nutrition programs is to promote health and prevent disease.



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Mr. ANDREWS. Thank you.  
Dr. Tinkelman.

**STATEMENT OF DAVID TINKELMAN, M.D., ON BEHALF OF  
JOINT COUNCIL OF ALLERGY AND IMMUNOLOGY; ASTHMA  
AND ALLERGY FOUNDATION OF AMERICA; AND NATIONAL  
ALLERGY AND ASTHMA NETWORK**

Dr. TINKELMAN. Mr. Chairman, my name is David Tinkelman, and I am a physician board-certified in pediatrics and in allergy and immunology. Currently, my academic appointment is clinical professor of pediatrics at the Medical College of Georgia. I am also in private practice in Atlanta, Ga.

I appreciate the opportunity to appear before you today on behalf of the Joint Council of Allergy and Immunology, an organization representing over 4,000 clinicians and researchers in allergy and immunology.

Also with me today are Barbara Layman, who is representing the Asthma and Allergy Foundation of America, and Nancy Sander, representing the Allergy and Asthma Network. These are two of the several lay groups which have been formed to address the concerns and needs of people who suffer from allergic and asthmatic disorders. They have come in support of this presentation and are available for any questions that the panel may have.

To begin, what is allergy and immunology and how does it affect us? Our bodies are constantly being challenged by foreign proteins. To protect us from disease, we have substances circulating in our blood stream which are called antibodies. When this system fails, people can acquire infections which may become life-threatening, as in AIDS.

In other persons, the problem is with an antibody present in substantial amounts in 20 percent of our population. Its presence causes various tissues of the body to react to normal exposures in an exaggerated and abnormal fashion, leading to hay fever, sinus infections, hives and asthma. In some people, the reaction leads to a severe life-threatening allergic event called anaphylaxis.

There are over 50 people who die each year from an anaphylactic reaction following an insect sting, and thousands more who end up in emergency rooms and hospital beds. This type of reaction is totally preventable. There are over 50,000 Americans receiving this life-saving preventable injection therapy today.

To wake up in the middle of the night wheezing and short of breath is a common experience for over 12 million Americans who have asthma. In 1987 alone, there were over 7,360 asthma deaths. Almost 500 of these were in children, and the mortality rate continues to increase at an alarming rate.

Prevalence in mortality rates for asthma are highest among inner-city and minority populations.

Direct cost for asthma care exceed \$3.6 billion annually. Indirect costs are approximately \$2.6 billion, including \$1 billion in lost wages for parents who stay at home to care for their ill children, and \$846 million in lost wages for adults with asthma.

Asthma is the most frequent cause for hospital admissions for chronic illness for children, and it leads the list of childhood dis-



eases that cause significant loss of time from school, which has been directly associated with a higher risk of failure in class.

Why is this the case, and what can we do? Most people do not realize that allergy is an integral part of the development of asthma, and that exposure to common substances such as dust can lead to severe life-threatening attacks. It is the responsibility of the allergist to identify the offending allergens, assess the severity of the disease and develop the best management plan for this disease.

Recently, two published studies, one in Kansas City and one in San Diego, demonstrated that those asthmatic patients referred to the allergists had fewer lost school and work days, a better quality of life, and in one of these studies a 50 percent reduction in emergency room visits, compared to those patients not evaluated and treated by the allergist/immunologist.

Twenty million Americans suffer considerably from their allergic nasal symptoms or the complications of the allergies, such as hearing loss from fluid behind their ears, ear infections, sore throats and sinus infections. Upper respiratory tract problems, including those caused by allergy or their complications, are the most common reason for physician visits in the child and one of the most common reasons for days lost from school and work.

Who is the allergist/immunologist? The allergist/immunologist has received at least 2 years of specialized training in the evaluation, function and treatment of the immune system in health and in disease and has passed the specialty examination. However, the single feature which makes the allergist/immunologist imminently qualified to deliver cost-effective quality health care to these patients is the fact that their basic focus is in the prevention, rather than the treatment of symptoms.

What is our role in the health care system of the future? We foresee the allergist/immunologist as the leader of research of allergic and immunologic diseases, as the leader in the educational process needed for both the general physician and the lay public, and as the corner stone in the diagnosis and management team.

We believe any minimum health care benefits package should provide for the needs of individuals with asthma and other allergic or immunologic disorders, particularly when so many millions of people suffer with these medical problems, and should allow for a timely, unrestricted access to the allergy/immunology specialist for evaluation and management services, and should prohibit preexisting condition restrictions.

There are 35 million people with allergic, immunologic and asthmatic disorders. It is the documented experience of researchers that prompt referral of people with these problems to allergists/immunologists results in better managed and more cost-effective care and a better quality of life for this population.

Thank you for the opportunity of presenting our views.

[The prepared statement and attachment follow:]



**TESTIMONY OF DAVID TINKELMAN, M.D.  
Joint Council of Allergy and Immunology**

Distinguished Chairman and members of the Subcommittee, my name is David Tinkelman and I am a physician, Board certified in pediatrics and in allergy and immunology. Currently, my academic appointment is clinical professor of Pediatrics at the Medical College of Georgia. I am also in private practice of allergy and immunology in Atlanta, Georgia. I appreciate the opportunity to appear before you today on behalf of the Joint Council of Allergy and Immunology. I request that my full written statement be placed in the record.

The Joint Council of Allergy and Immunology is a professional, nonprofit organization that is sponsored by the American Academy of Allergy and Immunology and the American College of Allergy and Immunology. We represent over 4,000 clinicians and researchers in allergy and immunology, working to alleviate the suffering of the 35 million Americans with allergic and immune disorders.

Also with me today are Barbara Layman who is representing the Asthma and Allergy Foundation of America ("AAFA") and Nancy Sander representing the National Allergy and Asthma Network. These are two of the several lay groups which have been formed to address the concerns and needs of people who suffer from allergic and asthmatic disorders. They have come in support of this presentation and are available for any questions that the panel may have.

I would like to address some points which we feel are essential for a better understanding of the medical, social and financial impact of allergy and immunology in the health care of Americans of today and in the future.

To begin, what is allergy and immunology and how does it affect us? Our bodies are constantly being challenged by foreign proteins. During the normal day, we eat many foreign proteins, breathe in foreign proteins with every breath, may be stung by a variety of different insects, and are in direct contact with thousands of bacteria and viruses in our daily environment. To handle these exposures in a manner which allows us to enjoy life and thrive in our environment without illness, discomfort or disease, we have a protective system circulating in our blood stream, which is made up of substances called antibodies which protect us.

In some people, this protective system is diminished, totally missing or does not function in the proper way, so that these people have many infections which end up being life threatening. We are all too well familiar with this when the immunity problem is acquired from the HIV virus and the person develops AIDS. In many persons, the problem is not with antibodies we are lacking, but rather an antibody that is present which we should not have. This antibody, called Immunoglobulin E or IgE, is present in substantial amounts in 20% of our population. Its presence causes various tissues in the body to react to normal exposures in an exaggerated and abnormal fashion. When this reaction occurs in the nose, ears, throat and sinuses there is swelling, sneezing, drainage, itching, and accumulation of fluid which is ready to become infected when exposed to common viruses and bacteria. When the reaction occurs in the skin, there is itching, redness, swelling, and dryness of the skin, called urticaria or eczema. When it occurs in the lung, there is inflammation in the airways causing swelling and mucus production leading to coughing, wheezing and difficulty breathing, which we call asthma. In some people, when certain foreign proteins reach the blood stream there is a sudden, violent and severe reaction in which all of these reactions can occur within minutes leading to a severe, life threatening, allergic event called anaphylaxis.

**Diseases Treated by Allergists/Immunologists: Their Social & Economic Magnitude**

The diseases most commonly treated by specialists in allergy and immunology include asthma (approximately 12.5 million people have asthma), anaphylactic reactions to food, drugs and insect stings (approximately 3 to 5 million Americans have these life threatening reactions), allergic and other chronic inflammatory nasal diseases which often accompany and complicate asthma (there are over 20 million people who suffer from these problems) and complications of these disorders such as sinusitis and ear, nose and throat infections. In fact, in a report by the Institute of Medicine, chronic sinusitis ranked number 1 among chronic conditions among the American population, with allergic rhinitis and asthma ranked number 5 and 10 respectively<sup>1</sup>. Specialists in allergy and immunology treat congenital deficiencies of the immune system and may also treat those afflicted with AIDS. Asthma, anaphylaxis and immune disorders such as AIDS are obviously severe life threatening conditions. Upper respiratory and skin conditions can also severely compromise the quality of life for those who suffer from them. The role of the specialist in allergy

and immunology is to identify the allergen or other factors in the environment which trigger asthmatic attacks or anaphylaxis as well as other allergic responses and to prevent these occurrences. Measurable cost-effective symptomatic improvement is accomplished through patient education about elements to avoid, medication and in some cases specific allergen immunotherapy - a process of giving injections of small amounts of protein to alter the allergic reaction.

### Impact of Asthma & Other Allergic Diseases

Approximately 20% of all Americans suffer from some type of allergic or immunologic disease with about 1/2 of them or 25 million people having active symptoms of one of these diseases or its complications at any one point in time. Most suffer chronic problems such as eczema, while others are faced with sudden life threatening reactions which can occur without warning such as an insect sting, drug, or food induced anaphylaxis.

Nothing can be more frightening for a person who is allergic to a stinging insect to be outside during a warm, sunny summer day with yellow jackets or bees flying around. There are approximately 50 people who die each year from an anaphylactic reaction following an insect sting and thousands more who end up in emergency rooms and hospitals beds. This type of reaction is totally preventable. Allergists are trained to utilize the available materials to skin test to determine the culprits to which the allergy has been established and to design a treatment program consisting of specific injections to these venoms to be given over a 5-year period. This well-defined program of therapy conveys life-long immunity or protection against these life threatening stings in almost 100% of the cases. There are over 50,000 Americans receiving this life-saving therapy today.

To wake up in the middle of the night wheezing, short of breath, and fighting for the next breath is a common experience for over 12 million Americans who have asthma. The prevalence rates of asthma were 40.1 per 1000 in 1987, and in that year alone, there were over 7360 asthma deaths, almost 500 of these in children. Asthma deaths increased by 6.8% in the 1980's.

While asthmatic episodes are usually reversible, they can be severe and are sometimes fatal. Prevalence and mortality rates for asthma are highest among inner city populations and minority populations. A recent discussion of the increase in asthma mortality as well as advances in treatment appears in the March 28, 1993 New York Times Magazine, a copy of which is attached to this testimony as an exhibit. Direct costs for asthma care exceeds \$3.6 billion annually. Indirect costs are approximately \$2.6 billion, including almost \$1 billion in lost wages for parents who stay at home to care for ill children and \$846 million in lost wages for adults with asthma (see Table 1).

**TABLE 1**

#### **Direct Medical Expenditures**

• Hospital Care	
Inpatient	\$1.6 billion
(Number of hospitalizations annually: 463,000)	
Emergency Room	\$295 million
(Number of annual visits: 1.81 million)	
Outpatient (in-hospital) physicians' services	\$190 million
(Number of outpatient visits: 1.51 million)	
• Physicians Services	
Inpatient	\$146 million
Outpatient	\$347 million
• Prescription medications	\$1.1 billion
All Direct Expenditures	\$3.6 billion

#### **Indirect costs**

• Lost work to care for children with asthma	\$900 million
• Lost work for adults with asthma	\$846 million
• Lost future earnings from premature deaths	\$819 million

All Indirect Costs	\$2.6 billion
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All Costs <sup>2</sup>	\$6.2 billion
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Asthma is the most frequent cause for hospital admissions for chronic illness for children and it leads the list of childhood diseases that cause significant loss of time from school. On average, asthmatic children miss twice as many school days as other children<sup>3</sup>, and one out of five children with asthma are absent more than 11 days of school per year, compared with only three percent of well children. Asthma attacks are the most common medical emergency for children. One-third of children with asthma are restricted in their physical activities. While children with asthma have only slightly higher rates of grade failure than well children, asthmatic children among lower income groups have twice the odds of failure compared with well children of similar income, and three times the risk of failure compared to asthmatic children from higher income families.

It should be pointed out that those people who currently have the least access to good allergy care live in the inner cities, and it is clearly been demonstrated by Malveaux<sup>4</sup> and Sly<sup>5</sup> in two different papers that there is a disproportionate rate of hospitalization, over-utilization of emergency care, and death in this population.

Why is this the case and what can we do? Most people do not realize that allergy is an integral part of the development of asthma as shown in the articles appearing in the New England Journal Of Medicine by Platts-Mills<sup>6</sup> on the relationship of allergy to the dust mite and the development of asthma and by Burrows<sup>7</sup> on the direct correlation of the appearance of the allergic antibody IgE and the presence and the severity of asthma. Most people do not realize there is a direct correlation of exposure of certain common proteins such as mold in the air and the development of severe life threatening asthma which was shown by O'Hollaren<sup>8</sup> in his article in the New England Journal of Medicine. It is the responsibility of the allergist to identify the offending allergens by appropriate testing, assess the severity of the disease by appropriate laboratory and pulmonary testing, and develop the best management plan combining avoidance of the offending proteins when possible, specific anti-inflammatory medications and in suitable cases the judicious use of immunotherapy or allergy injections to reduce the effect of the IgE on the allergic reactions causing the asthma.

In two recently published studies, one in Kansas by the Kansas City Asthma Care Project<sup>9</sup> and the other in San Diego by a group at Kaiser<sup>10</sup>, it was clearly demonstrated that those asthmatic patients referred to the allergists had fewer lost school and work days, a better quality of life and in San Diego a 50% reduction of emergency room visits compared to those patients not evaluated and treated by the allergist/immunologist. Can you imagine the medical and financial impact if all patients with moderate to severe asthma were treated in the same manner as in these studies? The lives saved, the hospital visits and admissions reduced, the billions of dollars saved.

### Other Allergic Diseases

Millions of Americans suffer considerably from their allergic nasal symptoms or the complications of the allergy such as hearing loss from fluid behind the ear drums, ear infections, sore throats, and sinus infections. Clearly, almost half the asthmatic population have upper airway allergic problems as well. Upper respiratory tract problems, including those caused by allergy symptoms or their complications are the most common reasons for physician visits in the child and one of the most common reason for days lost from school and work. The relationship between allergy involving the upper airway and the lower airway has been well established such that treatment of one often leads to better control of the other. Identifying the proteins responsible for the allergic symptoms and designing and implementing the proper management plan for the allergic patient has been shown repeatedly, in well-controlled studies, to be highly effective in reducing the need for medications, reducing sick visits and improving the quality of life in general.

### Why is an Allergist/Immunologist Necessary?

Who is the allergist/immunologist and what makes him or her more qualified to accomplish these medical and socioeconomic functions? To qualify for entry into an accredited 2- or 3-year allergy/immunology program, the physician must first complete training as a pediatrician or internist. To become board certified in the specialty, the physician must first pass an examination given by the pediatric or internal medicine boards and then pass the examination in allergy and immunology from the Combined Boards of Pediatrics and Internal Medicine. These individuals have specialized training in the function of the immune system in health and disease, and in the use of a history, laboratory tests, including pulmonary function testing, and skin testing in determining the degree of allergy and the offending proteins. There is specific training in



establishing comprehensive management plans including means of avoiding offending allergens, specific medications to deal not only with treating symptoms but also to alter the inflammation present which leads to the symptoms and the use of immunotherapy or allergy injections to alter the allergic state.

However, the single feature which makes the allergist/immunologist imminently qualified to deliver cost-effective quality health care to these patients is the fact that the basic focus of the allergist is the prevention rather than the treatment of symptoms. All the methods to identify the problem proteins are designed to implement prevention with education as the most effective means of avoidance, with the use of the most advanced prophylactic medications available to decrease the inflammatory state which in turn leads to chronic symptoms, and when necessary, with immunotherapy which helps to alter the allergic state by preventing the IgE reaction which leads to symptoms. Our goal is to prevent anaphylaxis, asthma attacks, hay fever, hearing loss from recurrent or chronic ear infections, and sinus infections, eczema and hives, and not merely to treat them!

What is our role in the health care system of the future? We foresee the allergist/immunologist as the leader in research to find better ways to diagnose and treat the millions of Americans with allergic and immunologic diseases. We see the allergist/immunologist as the leader in the educational process needed for both the general physician and the lay public to learn more about the processes involved in allergic and immunologic disease. We see the allergist/immunologist as the cornerstone in the diagnosis and management team to deal with the allergic, asthmatic and immunologic patient whose symptoms are not just a nuisance, but rather a medical problem which affects normal daily activity and work. Management of chronic problems involve a thorough, cost-effective approach to avoid chronic suffering. Such preventative therapy has been shown in study after study to improve quality of life, reduce medical costs in the long run, and kept our children and adults in school and at work leading productive and healthy lives.

We believe that any minimum health benefits package should provide for the needs of individuals with asthma and other allergic or immunological diseases, particularly when so many millions of people suffer with these medical problems.

#### **Specific Benefits That Should be Included In Any Basic Package**

Patients with allergic disease or asthma should have access to specialty care by physicians and basic benefits that include the following:

- evaluation and management services by a specialist who is trained and skilled in allergic, immunologic and asthmatic management;
- allergy and immunologic testing;
- pulmonary function testing;
- allergen immunotherapy including the costs of antigen preparation;
- prescription drugs;
- laboratory services;
- specific patient education and preventive services;
- nebulizers, peak-flow meters and spacer devices;

All of items listed above are essential parts of the medical arsenal for controlling allergic, asthmatic and immunologic disorders, and all, except for prescription drugs are covered by Medicare, primarily as physician services.

Prescription drugs are critical in controlling such diseases as asthma. Even though these medications may be costly, with appropriate use they can prevent even more expensive emergency room visits and hospital admissions.

Patient education/prevention has become a critical part of the management plan for allergic, asthmatic and immunological disorders as we are able to more precisely identify the source of the allergen which enables the patient to deal with their disease through lifestyle changes and modifications to the home or working environment.

Further, while we understand that there may be a need to place limitations on covered services, for example with respect to volume, such limitations should not be arbitrary and must be



consistent with credible professionally developed practice guidelines. Our specialty of allergy and immunology has developed practice guidelines for asthma care and we are in the process of developing some for allergic rhinitis. We would hope that professionally developed practice parameters such as these would be the basis for any limits set on covered services.

In addition, we are concerned about two issues related to the overall structure of health care reform. First, restrictions on reimbursement coverage for pre-existing conditions must be eliminated from any new program. Second, individuals must be guaranteed reasonable and timely access to specialists.

Any managed care system that is created as part of health care reform must use reasonable criteria for deciding when it is medically appropriate to refer a patient to a specialist. We are concerned about improper financial incentives currently offered to gatekeeper physicians by managed care systems as an inducement not to refer patients to specialists. While we believe the concept of a primary care physician should be central in managing and coordinating care among different physicians, we have serious concerns about any system which subjects the physician to financial penalties if referrals exceed a certain amount or rewards the physician for reducing care and not obtaining appropriate referral. In many ways this is the flip side of the self-referral issue: physicians receive financial rewards for providing care themselves rather than seeking appropriate referral. This is not only costly from a health perspective, but also results in more expensive care over the long term. An appropriate formula must be found to help control costs, save lives and promote health. We believe that the allergist/immunologist contributes to all these, both in philosophy and in practice.

Individuals with asthma and allergic diseases need to have appropriate referrals to allergists/immunologists. It is our experience that prompt referral of people with these conditions results in better managed and more effective care that ultimately reduces costs to the health care system because emergency room visits and hospital admissions are reduced. In addition, other societal costs such as loss of work days or school days can also be diminished.

We recommend that any health care reform package take a hard look at physician incentives not to refer. The Medicare system is in the process of developing regulations limiting such incentives for HMOs that have Medicare contracts. We would suggest that this process be reviewed, and that any proposal for reform include limits on incentives at least as stringent as those used by Medicare.

### **Summary**

We urge this Committee, in considering the contents of a basic medical benefit package, to keep in mind the 20% of Americans who suffer from asthma or other allergic and immunologic diseases. These conditions currently cost the health care system billions of dollars. We believe these costs can be significantly reduced if every American had access to timely and effective care. In particular, it is important that allergy and immunologic specialists be involved early on, in order to allow for greater prevention of symptoms and for more effective management of these allergic, asthmatic and immunologic disorders.

Thank you for the opportunity to present our views.

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April 21, 1993

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Brooks Sander, 14, and her mother, Nancy. Brooks' medication has gone from the pile at left to Ventolin (mother's hand), Beclomast (large inhaler) and Zaditen (pill)

IN THE END, IT TOOK MIKE IVEY, 20, only a few minutes to die. Though he'd had asthma since the age of 11, Ivey was an energetic, active young man. He attended Catholic University in Washington on an academic scholarship and played varsity football while also holding down a full-time job and helping raise his 2-year-old daughter.

But when he was rushed to the emergency room last fall, gasping for air like a man drowning, Ivey was already doomed. Two weeks earlier, he had begun using his inhaler more frequently to open up his bronchial airways and breathe more easily. Apparently he didn't realize that his increasing need for the inhaler meant something deadly was happening to his lungs.

His cousin brought Ivey into Providence Hospital in Washington at 8:24 P.M. on Friday, Sept. 18. At 8:40, Ivey went into respiratory arrest. 10 minutes later, his heart stopped beating. By 9:30, after all attempts to revive him had failed, the young scholar, athlete, husband and father was declared dead of asthma.

"Seeing those lungs at autopsy, I don't know how he was even breathing," says Dr. Margaret Barron, chairman of emergency medicine at Providence. "Kids like him, who are young and in good physical shape — strong heart, no coro-

# Asthma Kills

*In spite of drugs—  
and because of drugs—  
the death toll rises.*

BY ROBIN  
MARANTZ HENIG

Robin Marantz Henig, a Washington-based medical writer, is the author of "A Dancing Matrix: Voyages Along the Viral Frontier."

nary artery disease — don't need that much oxygen to keep going. So they manage to just get by — until the bottom falls out."

THIS IS A SCENE THAT SHOULD HAVE DISappeared with an earlier generation. Yet young people are still suffocating because of an entirely treatable disease. Throughout the 1980's, while deaths from childhood illnesses were declining for just about every other disease (besides AIDS), deaths from childhood asthma were on the rise.

The death rate in 1989 (the last year for which figures have been compiled) was nearly double what it had been in 1979. Among 5-to-14-year olds, the total number of asthma deaths is relatively low; most of the 5,000-plus people who die of asthma each year are elderly. But in the younger age group, the death rate has been increasing most rapidly, by an average of about 10 percent a year during the last decade.

The black-white gap in death rates also has been widening. In 1979, blacks were about twice as likely as whites to die of asthma; by 1987, they were three times as likely. And in the younger age groups, ages 15 to 44, death rates were about five times higher for blacks (as in the case of Mike Ivey) than for whites. Today, those most likely to die of asthma are poor, nonwhite, very old or very young and residents of inner cities, particularly the poorest neighborhoods of Chicago and New York. Asthma death rates in East



The increase in asthma is linked to the house dust mite, a microscopic bug that lives on dust specks, cast-off skin cells and traces of food.

Harlem, for instance, were nearly 10 times the national average in 1987.

Despite these sobering statistics, there remains a pervasive attitude, among physicians as well as patients, that asthma is not all that serious. Many people consider asthma a minor inconvenience, rather like hay fever, that most children eventually outgrow. This cavalier attitude may be the result, paradoxically, of the effective drugs now available to treat asthma symptoms. These drugs, known as beta-agonist bronchodilators, work so quickly and so well when inhaled that patients may be lulled into a false sense of security. A quick spritz helps them get their breath back within minutes, so they believe it always will. But if the underlying inflammation happens to be getting worse, as in the case of Mike Ivey, patients using inhaled bronchodilators might not even notice that their lungs are deteriorating until it's too late.

Two recent studies, conducted in Canada and New Zealand, suggest that asthma patients who rely most heavily on inhaled beta-agonist bronchodilators run twice the risk of dying. These observations might simply mean that the sickest people use the most drugs. But they could also be traced directly to the way the medication works. By opening airways that are normally constricted in an asthma attack, beta-agonists might actually expose the lungs to more of the very substances that damage them, hurdling the asthmatic individual down a dangerous spiral.

Even doctors don't fully appreciate asthma's power to kill. "It's an orphan disease from the point of view of the doctor's knowledge," says Dr. Peter König, director of the pulmonary and allergy division at the University of Missouri School of Medicine at Columbia. "I don't be-

lieve doctors would treat hypertension or diabetes with the same lack of understanding."

Not only is the asthma death rate rising, the prevalence rate for childhood asthma is going up, too. In 1981, 3.2 percent of American children under 18 had a diagnosis of asthma. By 1988, the proportion had grown to 4.3 percent, for a total of nearly three million children. Some of the increase can be attributed to better diagnosis. For years, physicians failed to recognize that childhood asthma often occurs without wheezing and would misdiagnose a chronic cough as sinusitis or recurrent bronchitis. But even taking this factor into account, experts believe there has been a real, worrisome increase.

"Just about every industrialized country where the pattern of asthma prevalence is studied has noticed an increase," says Dr. Kevin B. Weiss, an internist and epidemiologist at the George Washington University School of Medicine in Washington.

"When you see dramatic changes, you have to look for dramatic exposures." Among the most likely reasons for the increase in prevalence is the sharp rise in exposure to indoor allergens — like house dust mites and cockroaches.

As scientists investigate the mystery behind the rise in asthma deaths, and the slower but still steady rise in asthma prevalence, they are gathering new insight into the disease itself. Many now say that an emphasis on treating symptoms, most commonly with beta-agonists, has been misplaced. They say that for most patients asthma therapy should more properly resemble hypertension therapy — with anti-inflammatory drugs given on a regular schedule no matter how the patient feels — because asthma, like hypertension, can do its underlying damage silently, without

symptoms. And they say that more attention must be focused on the cause and on eliminating the common indoor allergens that initiate the disease.

**T**HE SYMPTOMS OF ASTHMA include wheezing, coughing, shortness of breath and difficulty in breathing out. During an asthma attack, as airways narrow, a person has a growing sensation of impending suffocation. This is often accompanied, not surprisingly, by the physical signs of panic: rapid heartbeat, sweating, dizziness. "What I remember most about attacks is watching her straining to lean forward to cough, her eyes bulging out of her head," says Nancy Sander of Fairfax, Va., whose 14-year-old daughter has had asthma since she was born. "But she didn't seem to be frightened; she seemed to just want air."

For most young people, the underlying process of asthma is an allergic response. Not every child with allergies has asthma, and not every child with asthma has allergies. But the relationship is extremely close.

"In our experience, 90 percent of asthmatics under age 18 have allergies," says Dr. Michael A. Kaliner, chief of the allergy branch at the National Institute of Allergy and Infectious Diseases in Bethesda, Md. "That's such a striking association that you can't dismiss the cause and effect. Once you have allergic asthma, your airways are more irritable. Then exposure to any irritant — exercise, cold air, a freshly painted room — can set off an attack."

Just as hay fever is an allergy in which the target organs are the eyes and throat, asthma is an allergy in which the target organ is the lung. It tends to occur in families where allergies are common. "People are born predisposed to have allergies and asthma," says Dr. Robert A. Wood, director of the pediatric allergy clinic at Johns Hopkins Hospital in Baltimore. "Allergy-prone people have a higher chance of developing allergies to whatever they are exposed to early in life."

The critical period of allergen exposure needed to begin an allergy seems to come surprisingly early, both for allergies that lead to asthma and for hay fever. According to several Scandinavian studies of hay fever victims, people tend to become allergic to whatever is circulating in the air in the first two or three months of life. In Helsinki, this means that babies born in February, March or April are more likely to develop hay fever, since birch tree pollen — one of the main environmental allergens in southern Finland — is at its height in early spring.

Asthma, on the other hand, tends to be associated with allergens found indoors, like dust mites, ani-

mal dander, cockroach droppings and secondhand cigarette smoke. I airight modern schools and homes: exposure to these indoor allergen is pervasive — and on the rise.

The culprit most commonly responsible for inducing asthma seems to be the house dust mite, a microscopic bug that lives on dust specks, cast-off skin cells and traces of food. "The dust mite thrives on increased humidity and warmth," Wood says. "It's fairly clear that dust mite exposure has increased over the past 10 years, a large part because of changes in home construction during the time."

In a classic study conducted in 1990, Dr. Thomas A. Platts-Mills and Dr. Richard Sporik had an English team that looked at about 85 children born into allergy-prone families, following them from birth to age 11. They found that children who grew up in the homes with high levels of dust mites were much more likely to have asthma, and to have more severe asthma, than children from the homes with low levels. The most critical period of exposure was before the age of 2.

Other studies have suggested a similar association between dust mite exposure and asthma genesis — though not necessarily exposure during the critical period of early childhood. In a remote region of the Papua New Guinea highlands, for instance, investigators in the early 1980's detected a stunning increase in asthma incidence — by some accounts, more than fortyfold — in the space of little more than a decade. During that period, the researchers found, a social change had taken place that might have accounted for the dramatic trend: people had begun to use cotton blankets at night. The blankets, it turned out, were a good environment for dust mites.

Another important contributor to the increase of childhood asthma in this country is maternal cigarette smoking. "The group in whom cigarette smoking has increased most dramatically in the U.S. since the early 1970's is women of childbearing age, between 15 and 35," says Dr. Scott T. Weiss, associate professor of medicine at the Harvard Medical School. "All other groups have gone down. But in this age group, the prevalence of smoking, which was once 5 percent, is now about 25 to 30 percent." Weiss and his colleagues analyzed data collected for the Federal study known as the National Health Interview Survey and found that in children whose mothers smoked during the early years, the risk of developing asthma more than doubled.

Significantly, Weiss found that the relevant period in a child's life for exposure to a mother's smoking begins in utero and ends at about age 3. After that, passive smoking no longer seems to increase asthma. (Continued on page 50)



Eric Wilson, left in 1979 to pursue a teaching career.

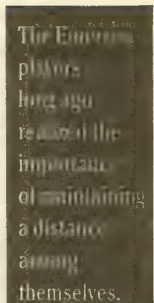
David Finckel, 41, and his wife, the pianist Wu Han, live in an Upper West Side apartment carefully decorated with objects that reveal Finckel's interest in poking around antique shops and discovering remote French Canadian woodcarvers. Up close, one feels the force of his slightly maniacal eyes, as well as the David Nivenish charm of someone who seems to be sharing a secret joke with himself.

An only child whose father, Edwin Finckel, began his career as a jazz pianist and arranger, Finckel spent his early years in "an old farmhouse outside Allentown, Pa., with no plumbing." Except for his father, all the other men in his family played the cello, and it was only a matter of time before he adopted that instrument as his musical voice. His father had a "phenomenal ear," and from an early age David was trained in the ability to listen, which is crucial to chamber music.

At 13, Finckel heard a recording of the Saint-Saëns cello concerto with Mstislav Rostropovich. "This was so beyond anything I'd ever heard," he recalls. "It was more emotional, more sensitive, more connected to the music. I fell in love." When Rostropovich made his first appearance at Carnegie Hall, Finckel was there. He became a Rostropovich groupie, and the two began a 10-year relationship during which the young disciple was able to take free lessons from the master. After a year at the Manhattan School of Music, Finckel worked freelance, playing, among other jobs, in the Colonial Orchestra in Madison, N.J., conducted by Oscar Shumsky.

"Phil, Gene and other New York households would trek out just to play under Shumsky, which is how I met them," says Finckel. "When they lost their cellist, Phil came over with a bottle of Scotch, got me plastered and I agreed to audition, even though I didn't know how I was going to put up with three brothers. When I sat down to play with Phil, Eugene and Larry, it was magic. I couldn't believe anything could sound so good."

STRING QUARTETS ARE notoriously fragile, but if the Emersons' chemistry seems remarkably durable it hasn't all been a matter of



chance. Years ago, they carved up the various functions of the group. Setzer is in charge of programming, subject to the approval of the others. He is constantly thinking of ways to shake up programs — for example, "sandwiching Haydn or Mozart between two contemporary works to put the old in greater relief." It was he who had the idea of performing all six Bartok quartets in one evening. The Emerson did their first Bartok marathon at Lincoln Center in 1981, a landmark event they have repeated several times since.

Finckel takes care of recording, taping many of the Emersons' concerts on his state-of-the-art equipment. "None of us is ever completely happy with what we've played — we're always tinkering," says Setzer. "But it's very hard to be objective. David's reports save a lot of arguing."

Drucker writes many of the program notes and is the group's most proficient linguist. Dutton keeps tabs on finances. "We gross over half a million a year," he says, "but when you deduct management fees and travel expenses and split it four ways, it comes out to no more than comfortable. You don't get rich playing in a string quartet."

The Emerson players long ago realized the importance of maintaining a distance among themselves. They have different travel agents, and though they generally stay at the same hotels, they are often surprised to run into one another on the same plane

Each finds musical outlets beyond the quartet. Finckel, for one, admits that the need to "compromise musically with three others" can be exhausting, and he tries to play as many recitals of the solo cello repertoire as he can with his wife, Wu Han. Frustrated that as a quartet musician he never has the opportunity to play Bach, Drucker has made a superb recording of Bach's solo violin sonatas and partitas. Another outlet is the group's teaching duties at the Hart School of Music in West Hartford, Conn. (A point of pride is the success of their chief protégé, a young Canadian group called the St. Lawrence Quartet, which recently took first prize in both the Banff and Young Concert Artists chamber music competitions.)

In their personal lives, the Emersonians have achieved an easy closeness. Setzer says: "We've all had to contend with troubles. David, for instance, had a seriously slipped disk, and Gene is watching his dad die of Lou Gehrig's disease. Fortunately, our wives get along with each other and we can all talk about these things. We also make a point of donating a half-dozen concerts a year to social causes — from nuclear disarmament to world hunger. The more we've let the outside world in, the more we've grown as a quartet." Adds Finckel: "Years ago, we agreed that the potential for agony in what we do was so great that if anyone was really unhappy we should not try to keep it going. I certainly can't imagine wanting to play in any lesser quartet than this. It wouldn't be worth it."

It's hard work, Setzer says, "but we all love to perform. And once in a while you have an experience that only being in a quartet like this can give you. A few winters ago in Germany, we recorded the Schubert C major String Quintet with Rostropovich playing the second cello part. It was in an old wooden church in a small town near Heidelberg. One night from 8 to 11, we did the great adagio movement. Outside, everything was blanketed with snow, everything was still. The only thing in the world was us, Rostropovich and Schubert. Thinking about it still gives me goose bumps." ■

## ASTHMA

(Continued from page 44)

incidence. But it does worsen asthma in children who already have it. "If an asthmatic child lives with a smoker in the home," Weiss says, "the child is more likely to be hospitalized."

THE UNDERLYING PROBLEM in asthma is bronchial hyper-responsiveness, more commonly known as "twitchy" lungs. Like the eyes and nose of a hay fever sufferer, the bronchi (the tubes through which air gets into the lungs) of an asthmatic are easily irritated. They go into spasm, secrete excess mucus and tighten in the presence of substances that would be quite harmless to ordinary airways. This extreme sensitivity probably is genetically programmed. "Hyper-reactivity has been shown to be present in asthmatics very early in life," König of the University of Missouri says. "And just to confuse the picture, it's also present in healthy relatives of asthmatics."

He says twin studies show that identical twins are more likely to be concordant for hyper-reactivity — that is, either both hyper-reactive or both normally reactive — than fraternal twins. This suggests a genetic base for twitchiness because identical twins share exactly the same genes, while fraternal twins do not.

Being born with unusually sensitive airways, then, seems to be the first stage in asthma genesis. The second stage is bronchospasm, in which the muscles surrounding the bronchi constrict, narrowing the tubes and limiting how much air can get to the tiny air sacs of the lungs. As these muscles constrict, the bronchi also start secreting mucus, and their linings begin to swell. This is the "early response" of an asthma attack, with all its frightening symptoms. This phase will last for half an hour to two hours unless treated with a bronchodilator, which works within minutes to release the tightened muscles and open up the airways again.

But drugs that relax muscles may not be sufficient in allergic asthma attacks. Several hours after the early response has abated, the immune system kicks in

with a "late response" that releases substances normally needed to fight infection. This misguided immune response causes inflammation of the bronchial linings that can last to 12 hours, even when bronchodilators have eased immediate problems. The ready twitchy lungs can even more easily irritate setting up conditions for another, perhaps more serious attack.

Five or 10 years ago, asthma control meant treatment of the bronchospasm — that is, occasional, symptomatic treatment of acute attacks — with much regard to the underlying condition. Now experts consider it more important to treat the chronic inflammation, to prevent attacks in the first place and to limit long-term damage to the lungs. This shift in philosophy has brought the drugs most commonly used to treat bronchospasm, the beta-agonist bronchodilators, under scrutiny.

ONE OF THE BIGGEST controversies among asthma specialists is whether inhaled beta-agonists are being misused. Having a beta-agonist bronchodilator in your pocket (sold under the brand name Brexair, Maxair, Proventil, Ventolin) is usually enough to make an asthmatic believe the disease is entirely under control. And no asthma specialists agree that these are, as Kallinger puts it, "wonderful drugs which provide quick, effective relief for most individuals, usually within about 15 minutes and lasting for 4 to 6 hours."

But the proper place of bronchodilators in the overall management of asthma is being reassessed. "A focus on bronchodilators as the only therapy is inappropriate," Kallinger says. "It's symptomatic therapy. It has nothing to do with the healing process."

By removing the warning signs that usually lead an asthmatic to get out of the way of the substances that can set off an attack, bronchodilators keep the lung open and exposed to potentially dangerous allergens.

"If you keep the patient with asthma completely bronchodilated, you enable

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him to do things he shouldn't do, like stay around allergens," says Platts-Milla, who is now head of the division of allergy at the University of Virginia School of Medicine in Charlottesville. Say a little boy has a cat allergy that sets off the wheezing and shortness of breath of an asthma attack. If he's in a room with a cat, his symptoms worsen and he gets out of there fast. But if he inhales a dose of a beta-agonist bronchodilator, he might sit in the room with the cat for hours, playing or watching television without any discomfort. The result: more antigen gets into his lungs, which leads to more inflammation and a worsening of the airways constriction that leads to attacks in the first place.

IN FEBRUARY 1992, A large-scale Canadian study showed a surprising relationship between the increasing use of bronchodilator and the increasing likelihood of death from asthma. "An increased risk of death or near-death from asthma was associated with the regular use of inhaled beta-agonist bronchodilators," wrote Dr. Walter O. Spitzer of McGill University in Montreal.

When the study first appeared in *The New England Journal of Medicine*, many patients became frightened of their own inhalers. "We received probably 1,500 calls in two weeks," says Nancy Sander of Fairfax, Va., president of the Allergy and Asthma Network, a self-help group founded seven years ago under the name Mothers of Asthmatics. "People were afraid their drugs were killing them and they wanted to take themselves off them. We tried to convince them all to talk to their doctors first."

For some people with asthma, including Sander's daughter Brooke, daily use of beta-agonist bronchodilators is part of the overall treatment plan. Brooke's asthma is severe enough, says her mother, that in spring, when pollen counts are high, she takes a dose of Ventolin four times a day in addition to her other asthma medications, no matter what her symptoms are.

In response to the worrisome reports about chronic use of beta-agonists, the American Academy of Allergy and Immunology is about to publish a position paper on

beta-agonists, emphasizing the need to monitor how much of it a patient is using. Anyone who comes to rely on more than one canister a month — each canister contains 200 metered doses of medication — is experiencing too many acute attacks and needs to adjust the basic underlying therapy, according to the academy.

"Although there is no proof that regular inhaled beta-agonists as a class increase morbidity and mortality in asthma, such a possibility exists," the academy's statement reads. "Gradual withdrawal of non-essential doses should take place until the patient is only using the medication for exercise, or for 'breakthrough' acute asthma symptoms."

Most asthma experts, led by those at the National Institutes of Health, say the first line of defense is anti-inflammatory drugs. Indeed, chronic, long-term, continuous treatment with anti-inflammatory medications — which are also generally given via aerosol inhalers — is the new hallmark of asthma therapy.

Two types of inhaled anti-inflammatories are available: cromolyn sodium and steroids. Cromolyn (sold under the brand name Intal) has virtually no side effects, but it can be quite costly — about \$60 to \$70 a month — and it doesn't work for everyone. "About half of all asthma patients get a good response to cromolyn, but it takes at least two weeks to see effects," Kaliner says. "With steroids, there's more reliability, it acts quicker [within three to five days] and the results are easier to see."

Inhaled steroids (sold as Aerobid, Azmacort, Beclovent and Vancort) are quite effective and relatively inexpensive — about \$25 a month — but many physicians are loath to prescribe them, especially to children, because of potential side effects. (The glucocorticosteroids prescribed for asthma are unrelated to anabolic steroids, which are misused by some athletes to build muscle mass.)

"The typical low doses used for inhaled steroids are probably very safe, even for children," says Wood of Johns Hopkins. "It's only a tiny minority of children who need steroid doses so high that they run into problems." Long-term use of the

highest doses of oral steroids can delay growth, thin bones and cause stomach ulcers.

But even anti-inflammatory drugs, promising as they are in preventing the complications of asthma, are no panacea. "In the past 10 or 20 years, there's been a massive increase in the sales of inhaled corticosteroids, but the corresponding decrease in hospitalization," says Platts-Milla of the University of Virginia. Part of the explanation may be that something other than inflammation is going on in the asthmatic lung — bronchial hyper-reactivity. No drug currently available adequately deals with hyper-reactivity, although researchers hope that some compounds under development will be able to interfere with the asthmatic process at an earlier stage, keeping the lungs from responding to allergens in the first place.

THE NEW APPROACH TO asthma management means that patients, even very young ones, must take an active role in their ongoing care. Central to this is the use of a home device known as a peak flow meter. Like other devices used to monitor chronic conditions — blood pressure cuffs for hypertensives, urine dipsticks for diabetics — peak flow meters can indicate underlying problems long before they become symptomatic.

Brooke Sander, for instance, uses her peak flow meter daily in the morning, breathing forcefully into a short hollow tube that records the rate of air she can force out of her lungs. If her peak airflow drops below a particular level, Brooke increases her medication accordingly. If it drops farther still, she informs her mother and her doctor. With this routine, Brooke has stayed out of emergency rooms for eight years.

Present knowledge has come a long way from a generation ago, when childhood asthma was considered a psychosomatic illness caused by an over-demanding mother and a high-strung child. But now that the origins of asthma are more accurately understood, the next steps are to stop the troubling rise in asthma incidence, to treat it aggressively day in and day out and to give this potentially deadly condition the respect it deserves. ■

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Mr. ANDREWS. Thank you.  
Dr. McAndrews.

**STATEMENT OF JEROME F. McANDREWS, D.C., VICE PRESIDENT FOR PROFESSIONAL AFFAIRS, AMERICAN CHIROPRACTIC ASSOCIATION**

Dr. McANDREWS. Good morning, Mr. Chairman.

I am Dr. Jerome McAndrews, vice president for professional affairs of the American Chiropractic Association. On behalf of the ACA, I would like to express my appreciation to the committee for this opportunity to present our views, particularly on a structure of a basic benefits package.

The ACA is a professional society of 23,000 members. As the profession's largest organization, the ACA has taken a leading role in support of health reform proposals to expand access to health care services to all Americans, lower health care costs, maintain and enhance the quality of health care and ensure that Americans are guaranteed the right to select the health care provider of their choice.

The ACA realizes that the high cost of care is due in part to benefit plans that fail to control overutilization, curb inappropriate care or which rely too heavily on expensive high-tech procedures. This is a serious problem which strains our economy and pushes the cost of coverage out of the reach of small businesses and individuals.

Indeed, assuring that Americans have access to a range of services and various health providers is central to ensuring the competition necessary to achieve cost control. The ACA is convinced it is possible for a better health care system to be both comprehensive and cost-efficient.

Most observers agree on the nature of the benefits that should appear in a basic benefits package. Whatever specific services are covered in a standard benefits package, ACA believes its successful reform must guarantee patients the freedom to choose their provider.

In our view, a responsible health benefits package must provide access to the full range of services D.C.s are licensed to perform. We think there are at least three good reasons: First, millions of Americans currently use chiropractic services; second, chiropractic is high-quality low-cost care that saves millions and probably billions of health care dollars; and, third, D.C.s provide important primary health care services which are key to health promotion and disease prevention.

Chiropractic services are utilized extensively and are covered under most health care plans. D.C.s served approximately 19 million patients in 1990, and annually they treat about 7.5 percent of the population. Eighty-five percent of employers recently surveyed by the HIAA said they provided employees with chiropractic coverage under both fee-for-service and managed health care plans.

The mere fact that a particular form of health care is widely covered and utilized under the current system does not necessarily qualify it as an essential element of a standard benefits package. Chiropractic care, however, has been proven an effective and low-cost treatment in the care of many pervasive health care problems.



Most prominent among the health problems treated by D.C.s are neuromusculoskeletal ailments which, according to ACA's annual survey, cover 392 different diagnostic codes. These ailments include dysfunction of the musculoskeletal joints or articulations and related pain.

Eighty percent of all Americans will suffer back pain at one time or another in their lifetime. Twenty percent of all military medical discharges are due to low back pain. The evidence of chiropractic ability to successfully and cost-effectively treat these conditions is incontrovertible. Several recent studies are referenced in my prepared statement, one of which, published in the British Medical Journal, concluded, "Chiropractic treatment was more effective than outpatient management or inpatient management, mainly for patients with chronic or severe back pain."

A Rand Corp. spokesman recently said: "There are considerably more randomized controlled trials which show benefits of chiropractic than there are for many, many other things which physicians and neurosurgeons do all the time."

A recent Gallup survey found that 90 percent of chiropractic patients felt their treatment was effective. A study comparing medical and chiropractic care for treatment of identical back injuries found that the number of work days lost was 10 times higher for medical patients than for chiropractic patients. In addition, compensation cost for work time lost averaged only \$68 for chiropractic versus \$668 for medical patients.

Another study found chiropractic patients were three times more satisfied with their care than patients of family physicians. By every test of cost and effectiveness, the general weight of evidence shows chiropractic to provide important therapeutic benefits at economical costs. Ninety-four percent of manipulation of dysfunctions of the musculoskeletal system are provided by doctors of chiropractic, as reported by Rand.

Scientific studies suggest that the specific approach of the DC is significantly more effective than other modalities, up to twice as effective at half the cost, and returning patients to normal activities in half the time. Over 25 randomized clinical trials showing chiropractic superior effectiveness have been published over recent years. Other retrospective literature of views going back 20 years also show a 2-to-1 superior effect of chiropractic care.

Under State licensure, D.C.s have the authority and obligation to report communicable diseases, diagnose any and all health care conditions and, when appropriate, refer patients to other health providers. In carrying out their diagnostic requirements, they serve as primary providers.

A recent editorial in the Journal of Family Practice found three largely unfounded "misperceptions" certain allopathic physicians have about chiropractors, to wit: one, they are poorly trained and, thus, could fail to diagnose a serious disease; two, spinal manipulation lacks a scientific basis; and three, manipulation is a dangerous intervention.

The article dispels these misperceptions by stating that chiropractors one, are well-educated, two, take care of more back pain visits than do medical doctors, three, are reimbursed widely by both government and private insurance plans, and four, provide



more satisfaction with their care than do family physicians. It seems obvious, then, that the services they provide should be fully covered under a standard benefits package.

The remainder of my prepared statement deals, I believe, in an important way with the self-admission by a former President of the American Academy of Orthopedic Surgeons that they are unqualified to act as gatekeepers for functional disorders of the neuromusculoskeletal system, and there are several indications in my testimony that will show that from them, that their colleges do not train in this area and that there should be a parallel gatekeeper system setup that would consist of chiropractors who would screen people for musculoskeletal problems, and if there was a need for them to see a different type of health provider, they are qualified to make such a referral.

Thank you for listening, Mr. Chairman.

[The prepared statement follows:]

## TESTIMONY OF JEROME F. MCANDREWS, D.C.

## VICE PRESIDENT FOR PROFESSIONAL AFFAIRS

## AMERICAN CHIROPRACTIC ASSOCIATION

Good morning. I am Dr. Jerome McAndrews, Vice President for Professional Affairs at the American Chiropractic Association (ACA). On behalf of the ACA, I would like to express my appreciation to the Committee for this opportunity to present our views on the issue of health care reform, specifically on the structure of a basic benefits package. I will be pleased to respond to any questions which might be stimulated by this testimony.

The ACA is a professional membership society of 23,000 doctors of chiropractic (D.C.s) and chiropractic students. As the profession's largest organization, the ACA has taken a leading role in support of health reform proposals to expand access to health care services to all Americans, lower health care costs, maintain and enhance the quality of health care and ensure that Americans are guaranteed the right to select the health care provider of their choice. In the last two years, ACA has testified in support of these goals before both this subcommittee and the full Committee on Ways & Means. In addition, just last month, ACA testified before the President's Task Force on National Health Care Reform. ACA is proud to be leading the chiropractic profession during these historic times and looks forward to working with you, Mr. Chairman, and the other members of this subcommittee to see needed health reforms become reality.

## BENEFITS

The ACA commends the subcommittee for focusing on the content of a standard benefits package -- an issue which is central to the ultimate success of any health reform proposal. Surely, the structure and content of the benefits package is the one element of health care reform that will have the most immediate impact on health care consumers. As such, it is perhaps the most politically important element of the health care reform proposal that President Clinton and the Congress will address. As the members of this subcommittee know, eighty-five percent of all Americans currently enjoy access to health care coverage. A reduction in the level of services they now receive may leave many wondering how health care reform has benefited them.

On the other hand, the ACA realizes that the high cost of care is due in part to benefit plans that fail to control overutilization, curb inappropriate care or which rely too heavily on expensive "high tech" procedures. This is a serious problem which strains our economy and pushes the cost of coverage out of reach for many businesses and individuals.

Given these realities, the challenge to lawmakers and the provider community is to determine the correct balance between comprehensiveness of benefits and cost containment. ACA believes that these are not mutually exclusive. Indeed, assuring that Americans have access to a range of services and various health providers is central to ensuring the competition necessary to achieve cost control. The ACA is convinced it is possible for a better health care system to be both comprehensive and cost efficient.

ACA supports a comprehensive benefits package. If that package emphasizes primary care, preventative care and wellness, as we feel it should, it will not necessarily result

in higher health care costs. Since primary and preventative care helps detect health problems before they become serious and expensive to treat, they reduce the need for hospital-based, heroic care. Such services also educate patients about healthy lifestyles and injury and sickness avoidance. In short, the benefits covered under national health reform should help steer our system away from high-tech, procedure intensive care toward holistic, preventative care. Otherwise we build upon the current dysfunctional system which waits for illnesses to occur rather than one that attempts to prevent them.

Most observers agree on the nature of the benefits that should appear in a basic benefits package. They include, but are not limited to: physician services, including the services of state licensed health care providers; inpatient and outpatient hospital services; post-hospital skilled nursing facility services; ambulatory, preventative and rehabilitative services; prenatal care, well-child care, family planning services, mammography, pap smear, and counseling services to prevent illness; and treatment of mental illness and substance abuse.

Whatever specific services are covered in a standard benefits package, ACA believes that successful reform must guarantee patients the freedom to choose their provider. If a provider is licensed to perform a service that is covered in the basic package, fairness dictates that patients should be permitted to select that particular provider for treatment. Excluding providers who are trained and licensed to treat covered conditions, or provide covered services, is completely contrary to the notion of expanding health care access to all. If the country is to meet the goal of universal coverage, it must make use of all health provider resources, including non-MD providers such as doctors of chiropractic (DCs).

### THE ROLE OF CHIROPRACTIC

In our view, a responsible health benefits package must provide access to the full range of services DCs are licensed to perform. We think there are at least three good reasons. First, millions of Americans currently use chiropractic services. Second, chiropractic is high quality, low cost care that saves millions of health care dollars. And third, DCs provide important primary health care services which are key to health promotion and disease prevention.

#### Extensive Utilization

Chiropractic services are extensively utilized and covered under most health care plans. Doctors of chiropractic (DCs) served approximately 19 million patients in 1990<sup>1</sup> and annually they treat about 7.5% of the population.<sup>2</sup> Eighty-five percent of employers recently surveyed by the Health Insurance Association of America said they provided

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<sup>1</sup> *Demographic Characteristics of Users of Chiropractic Services*, The Gallup Organization, 1991.

<sup>2</sup> *Journal of Family Practice*, Vol. 35, No. 5, November 1992.

employees with chiropractic coverage under both fee-for-service and managed health care plans.<sup>3</sup> In addition, the federal government has long covered chiropractic under Medicare, Medicaid, federal workers compensation and the federal employees health benefits program. DCs are also recognized to serve as commissioned officers in our military and to perform physical examination services under authority of the U.S. Department of Transportation.

Given the high level of chiropractic coverage throughout all segments of society, exclusions or limitations of these services would be tantamount to a reduction in the levels of care that Americans need and expect. We know of no policymaker who has suggested reforming the system by decreasing access to care.

### High Quality, Low Cost

The mere fact that a particular form of health care is widely covered and utilized under the current system does not necessarily qualify it as an essential element of a standard benefits package. While extensive coverage of chiropractic is a powerful reason for its inclusion in a basic benefits package, one problem with the current system is that certain benefits are overutilized, of questionable merit or excessively priced. This is not the case with chiropractic care, however, which has been proven an effective and low cost treatment in the care of many pervasive health care problems.

Most prominent among the health problems treated by DCs are neuromusculoskeletal ailments which, according to ACA's annual survey, cover 392 different diagnostic codes. These ailments include dysfunction of the musculoskeletal joints (articulations) and related pain.

The health conditions most often treated by DCs are those pertaining to the nation's number one malady -- back pain. Some 80% of all Americans will suffer from back pain at some point during their lifetime, 50% this year alone. The problem is so pervasive that 20% of all military medical discharges result from this ailment.<sup>4</sup>

The evidence of chiropractic's ability to successfully and cost effectively treat these conditions is incontrovertible. Several recent studies are referenced below:

- \* In June of 1991, the *British Medical Journal* published the results of a study comparing chiropractic and hospital outpatient treatment for managing low back pain. Patients were followed for up to two years with eleven chiropractic and hospital outpatient centers being used.

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<sup>3</sup> *Business & Health*, December 1991.

<sup>4</sup> "Low Back Pain: A Practical Approach To Management", *Consultation Report #89-001, U.S. Army Health Care Studies and Clinical Investigation Activity*, 1989.



Results: "Chiropractic treatment was more effective than outpatient management, mainly for patients with chronic or severe back pain. A benefit of about 7% points on the Oswestry scale was seen at two years. The benefit of chiropractic treatment became more evident throughout the follow-up period. Secondary outcome was more beneficial." (Since the Oswestry Scale is logarithmic -- such as is the Richter Scale -- 7% points is equal to 75% to 200% better.)

Conclusions: "For patients with low back pain in whom manipulation is not contraindicated chiropractic almost certainly confers worthwhile, long term benefit in comparison with hospital outpatient treatment."<sup>5</sup> (Emphasis added.)

- A RAND Corporation spokesman recently said, "There are considerably more randomized controlled trials which show benefits of this (chiropractic) than there are for many, many other things which physicians and neurosurgeons do all the time."<sup>6</sup>
- A recent Gallup survey found that 90% of chiropractic patients felt their treatment was effective and that 80% had their expectations met.<sup>7</sup>
- A study comparing medical and chiropractic care for treatment of identical back injuries found that the number of work days lost was ten times higher for medical patients than for chiropractic patients. In addition, compensation costs for work time lost averaged \$68 for chiropractic versus \$668 for medical patients.<sup>8</sup>
- Analysis of a data-base of 2 million patient claims found that, for treatment of the most common neuromusculoskeletal conditions treated by all health disciplines, "chiropractic users tend to have substantially lower total health care costs."<sup>9</sup>
- Another study found chiropractic patients were three times more satisfied with their care than patients of family physicians.<sup>10</sup>
- "By every test of cost and effectiveness, the general weight of evidence shows chiropractic to provide important therapeutic benefits, at economical costs. [T]hese

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<sup>5</sup> *British Medical Journal*, 2 June 1990, Vol. 300, Number 67137.

<sup>6</sup> *ABC's 20/20*, Paul G. Shekelle, MD ,MPH, February 21, 1992

<sup>7</sup> Gallup, op. cit.

<sup>8</sup> *Journal of Occupational Medicine*, Vol. 33, Number 8, August 1991.

<sup>9</sup> *Journal of American Health Policy*, Vol. 2, Number 6, Nov./Dec. 1992.

<sup>10</sup> *Western Journal of Medicine*, Vol. 150, 1989.

benefits are achieved with apparently minimal, even negligible, impacts on the costs of health insurance."<sup>11</sup>

Chiropractic achieves these kind of results through its primary treatment therapy, manipulation. In 1990 the RAND Corporation found manipulation to be an "appropriate treatment" for low back pain.<sup>12</sup>

Spinal manipulation, 94% of which is provided by DCs, is a treatment modality which is designed to restore normal function to a musculoskeletal joint causing disability and/or pain. It consists of providing a sufficiently specific maneuver to the affected joint (articulation) to achieve this end. Its purpose is to mobilize the joint, thereby returning it to its normal function and allowing other parts of the musculoskeleton -- which often compensate to the improper functioning joint(s) -- to return to their normal relationships and function as well.

The point of describing this therapy is to:

1. Describe the primary treatment method of the D.C.; and,
2. Differentiate such treatment from that of other provider groups. Scientific studies suggest that the specific approach of the D.C. is significantly more effective than other modalities: up to twice as effective at half the cost, and returning patients to normal activities in half the time.

This testimony cannot hope to set forth all the evidence indicating the preference for chiropractic treatment over other forms. Over 25 randomized clinical trials showing chiropractic's superior effectiveness have been published over recent years. Other retrospective literature reviews going back twenty years also show a two to one superior affect of chiropractic care. The ACA has made many of these studies available to Congress and would be delighted to provide them to the subcommittee at your request, Mr. Chairman.

#### Primary Care Providers

It is understood that expanding access to health care and lowering its costs cannot be realistically achieved unless the current high-tech, procedure intensive and specialty oriented system is replaced with a health care model focused on primary care and prevention. The failure of medicine to provide an adequate supply of primary care providers is well documented. If we are to have a sufficient complement of primary care providers, one thing public policies must do is emphasize the role of primary, non-M.D.

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<sup>11</sup> Schiffrin, L.G., *Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Assessment, with Implications for the Commonwealth of Virginia*. The College of William & Mary and Medical College of Virginia, Jan. 1992.

<sup>12</sup> Rand Corporation, *The Appropriateness of Spinal Manipulation for Lower-Back Pain*, 1992.

health providers, such as doctors of chiropractic. Chiropractic physicians currently serve as primary care providers to millions of Americans. This is especially true in rural areas where DCs are often the only source of health care for miles. Federal policymakers would be remiss if they failed to structure a health care benefits package that did not explicitly cover all primary care providers, including DCs. Expanded coverage of chiropractic services will take advantage of a health care profession of 45,000 which is dedicated to the delivery of conservative, high quality and low cost health care.

Unfortunately, health care policymakers often fail to realize that DCs provide a range of primary and diagnostic health care services. The traditional conception of primary care has been limited to the medical care provided by general practitioners and family physicians. However, upon close scrutiny of the essential elements of primary care, it becomes clear that chiropractic is a primary care profession.

Consider the central features of primary care. It is "direct access" care; patients need not be referred to a primary care provider. It is integrated care; it is oriented toward "wellness" and the whole patient, not merely a specific body part. And it is diagnosis-based; it serves as a "portal of entry" into the system where patients are assessed and cared for or referred to a provider best suited to attend to their problems. It is obvious to anyone familiar with the practice of chiropractic that it meets each of these criteria.

Some will attempt to dispute this notion. Those that do, however, are simply ignorant of the comprehensiveness of chiropractic education and the nature and scope of a DC's practice. Chiropractic students receive broad-based training in the basic and clinical sciences, chiropractic technique, differential diagnosis and referral. Under state licensure, DCs have the authority and obligation to report communicable diseases, diagnose any and all health care conditions, and, when appropriate, refer patients to other health providers. In carrying out their diagnostic requirements, DCs utilize common health care procedures such as physical examination, laboratory tests, x-rays and other common diagnostic services.

No less an authority than the U.S. Public Health Service has recognized the chiropractor's diagnostic authority. In its *Eight Annual Report on the Health Professions*, the agency declared that the four year chiropractic curriculum provides instruction in "the essential facts required for diagnosis, prognosis and treatment of disease".<sup>13</sup> In addition, one of the country's largest insurers, State Farm, has stated that the chiropractic curriculum "closely parallels" that of medical school and, in the case of anatomy, physiology, rehabilitation, nutrition, public health and other subjects, it often requires more hours of instruction.<sup>14</sup>

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<sup>13</sup> U.S. Public Health Service, *Health Personnel in the United States, Eighth Report to Congress*, 1991.

<sup>14</sup> State Farm Insurance Companies, *MediClaim*, Nov. 1992.

Chiropractic continues to grow in acceptance among the "traditional" physician community as well. A recent editorial in the *Journal of Family Practice* found three largely unfounded "misperceptions" certain allopathic physicians have about chiropractors. To wit: 1) they are poorly trained and thus could fail to diagnose a serious disease; 2) spinal manipulation lacks a scientific basis; and, 3) manipulation is a dangerous intervention. The article dispels these misperceptions by stating that chiropractors: 1) are well educated; 2) take care of more back pain visits than do medical doctors; 3) are reimbursed "widely" by both government and private insurance plans; and, 4) provide more satisfaction with their care than do family physicians.<sup>15</sup> We are pleased, of course, that the atmosphere of collegiality continues to grow between traditional medicine and chiropractic. The ACA is dedicated to doing that which is best for health care consumers, and the building of professional bridges is an important way to serve that end.

In short, Mr. Chairman, DCs are primary care providers, their services have been proven cost effective and millions of Americans benefit from their care. Therefore, we feel that any appropriate health benefits package will cover the full range of chiropractic services as they are determined under State law. If it does not, the Administration and Congress will be derelict in their duty to provide affordable basic health care services that emphasize primary and preventative care. It seems obvious, then, that the services they provide should be fully covered under a standard benefits package.

#### FREEDOM OF CHOICE

Inclusion of chiropractic benefits in a standard benefits package will be of little consequence, however, unless Americans are assured the freedom to choose their health care provider. All too often, health delivery systems are permitted to deny patients access to their providers of choice robbing them of the care that serves their special health care needs. Freedom of choice is fundamental to this country's traditions and should not be compromised under a reformed health care system. While ACA is heartened that President Clinton has endorsed the principal of free choice of provider, it is nonetheless concerned that his reform plan may not go far enough in securing this right for Americans.

In recognition of the patient's unassailable right to choose, the vast majority of states have enacted provider freedom of choice laws guaranteeing access to the services of DCs and other licensed non-MD health care providers. (Forty-one states guarantee access to chiropractors specifically.) It is important to stress that these laws do not "mandate" coverage of additional health care services. Rather, they merely expand the pool of providers eligible to deliver services that are already covered under health benefits plans.

ACA would recommend in the strongest terms possible, that any health reform proposal offered by the Administration or considered by Congress, contain an iron-clad guarantee that patients enjoy the maximum choice possible in selecting the provider of their care.

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<sup>15</sup> *Journal of Family Practice*, op. cit.



Such a guarantee could be achieved through explicit provider anti-discrimination language modeled after State insurance equality laws. Such language might read as follows:

"Notwithstanding any other provision of law, the health benefits plans established under this section shall provide for coverage of the services rendered by duly licensed health care professionals if such services (1) treat a condition covered under such plans, and (2) are within those services such health care professionals are licensed to perform."

Again, this language would not mandate coverage of additional benefits, as its opponents would maintain. To the contrary, it would simply allow patients the freedom to choose their health care provider for treatment of conditions already covered under their health plan. And, as the study referenced earlier in this testimony shows, insurance equality laws have "minimal, even negligible, impacts on the costs of health insurance."<sup>16</sup>

### BARRIERS TO FREEDOM OF CHOICE

Why is a strong freedom of choice provision necessary? This Committee undoubtedly knows of the "long term, systematic, successful and illegal boycott" of the chiropractic profession conducted by the American Medical Association from 1961 to 1992.<sup>17</sup> During the boycott, it was AMA's official policy that association with, or referral of patients to, doctors of chiropractic was unethical. We may never know fully the extent of the boycott's damage to the American public. Undoubtedly, in terms of unnecessary hospitalizations and surgeries, the direct and indirect costs to society and individuals was tremendous. And, in terms of the chiropractic profession's standing within the American health care establishment, the costs were no doubt equally as high. As the presiding judge in the Wilk case said, "reputations were destroyed."

#### Managed Care

Given this sad chapter in our Nation's health care history, one can understand why my profession is so anxious about the coming reforms -- and so adamant about the need to preserve the patient's freedom to choose a DC. We are especially concerned with health reform plans that would increase the use of managed care arrangements. This is especially the case with "managed competition" which has been endorsed by the Clinton administration. To the degree that managed competition places medical doctors in positions of control over doctors of chiropractic and other non-MD providers -- those with whom they are in professional and economic competition -- it will be a system that preserves elements of the monopoly that the Wilk decision was meant to remedy. In short, it will establish a "fox guarding the hen house" scenario that will ultimately be to the patient's detriment.

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<sup>16</sup> Schiffrin, op. cit.

<sup>17</sup> *Wilk v. AMA*, 895 F 2d 352 (cert. den. 110 S.Ct. 2621, June 11, 1990.)

How do we assure that truly cost effective, and competitive elements find their way into managed competition? We feel the answer is the establishment of a parallel gatekeeper system, put in place at every managed care location. Under such a system, every patient suffering from a condition related to musculoskeletal injury or pain would be evaluated first by a chiropractic gatekeeper. Such conservative, non-invasive expert evaluation, in and of itself, could save millions. More importantly, however, the chiropractic gatekeeper would be able to refer cases to a chiropractic physician for treatment, when warranted, or make any necessary referrals to the medical gatekeeper for further consideration. This amounts to little more than extending the DCs existing state granted "direct access" status to managed care networks. And since DCs are authorized under state law to diagnose and refer, this is a fully appropriate, and wise, use of their capabilities.

The reverse of the above is not possible. As the court made clear in the Wilk case, the medical gatekeeper is untrained to either diagnose or treat problems with the dynamics of the neuromusculoskeletal (NMS) system, including the spinal column. The chiropractor, on the other hand, is trained not only to diagnose NMS problems, but also to differentially diagnose cases requiring medical review.

The following testimony from the Wilk case is illustrative. It was given by leading orthopedic surgeon, Dr. John McMillan Mennell who taught in eight American medical colleges:

- A. ....if you ask a bunch of new residents who come into a hospital for the first time how long they spent studying the problems of the musculoskeletal system, they would, for the most part reply, "Zero to about four hours." I think that was my testimony.

...

- Q. The musculoskeletal system comprises what portion of the body?  
A. As a system, about 60 percent of the body.

- Q. Is it your testimony that the residents to whom you just referred told you they had no training whatsoever relating to problems as to 60 percent of the body?

- A. And that is just about right.

...

- Q. Is it your testimony that it is your understanding that the entire medical school curriculum is devoted to about 40 percent of the body?

- A. Yes, sir.

...

- Q. The normal medical practitioner goes through first four years of undergraduate school, is that correct?
- A. Yes.
- Q. And then the practitioner goes through four years of medical school, is that correct?
- A. Correct.
- Q. So that is anywhere from nine to 14 years, 13 years.
- A. They still come out of school and say pain in the elbow is tennis elbow. I don't know what that means.
- Q. During that time - I think I added it quickly, it is 13 years - during that nine to 13 years that training is devoted to 40 percent of the body, is that correct?
- A. That is correct.

While Dr. Mennell was referring to new medical residents, consider the following testimony of the widely respected John C. Wilson, Jr., M.D., chairman of the American Medical Association's section on orthopedic surgery and, later, president of the American Academy of Orthopedic Surgeons. Dr. Wilson's conclusion was that medical doctors and orthopedic surgeons were essentially ignorant of the causes and corrections of low back problems.

"When queried about the lower back a medical student soon to graduate from a far Western University revealed an enormous gap in his professional education. One instructor had given him a list of 125 causes of low back pain, from which the student had concluded that probably everyone with sciatica had a ruptured disc requiring surgery; another instructor had delivered a one-hour lecture on anterior interbody fusion. This young man, well informed concerning the cause and treatment of cardiac arrhythmias, electrolyte imbalance, and alterations in the DNA chain, displayed a disturbing ignorance of the cause and treatment of low back and sciatic pain - one of mankind's most common afflictions.

The teaching in our medical schools of the etiology, natural history, and treatment of low back pain is inconsistent and less than minimal. The student may or may not have heard a lecture on the subject, he may have been instructed solely by a neurosurgeon, or the curriculum committee may have decided that clinical lectures are "out" and more basic sciences "in." The orthopedic surgeon, to his distress, often sees his hours in the curriculum pared to the barest minimum.

A survey of orthopedic residents graduating from an approved program in a large urban area disclosed several alarming deficiencies in their training. They know very little about the natural history of degenerative disc disease in the lower part of the spine. The importance of the physician's personally taking an accurate, detailed patient history had escaped them. They were too unsure of the technique of careful lumbar spine examination to include a search for early stages of neurologic deficit. They had too often been satisfied with interpretations of technically inferior roentgenogram, and their insufficient knowledge of diagnostic aids seldom permitted them to select the one most helpful in accurately establishing the level of a lesion. They knew least when to use a particular surgical procedure.

At the postgraduate level, symposia and courses concerning the cause and treatment of low back and sciatic pain are often ineffective because of prejudices and controversy.

These inconsistencies spawn disastrous sequelae:

1. patients operated upon after inadequate evaluations;
2. reliance by physicians on poor quality x-ray films;
3. surgery done only because of an abnormality in a myelogram without reference to plain films of the lower spine;
4. exploratory surgery upon the lower back done without sufficient clinical basis;
5. extensive surgery done for solely subjective complaints;
6. repeated attempts at spinal fusion - sometimes six or eight - by surgeons of limited experience;
7. surgery authorized by industrial accident commissions comprised exclusively of laymen; and
8. extensive removal of posterior vertebral elements by neurosurgeon, making stabilization of the lower portion of the spine technically difficult if not impossible."<sup>18</sup>

And, according to the judge in the Wilk case:

"But, according to the court (and this is unchallenged), at the same time, there was evidence before the (AMA) committee that chiropractic was effective, indeed more effective than the medical profession, in treating certain kinds of problems, such as back injuries. The committee was also aware, the court found, that some

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<sup>18</sup> "Low Back Pain and Sciatica," *JAMA*, May 22, 1967.



medical physicians believed chiropractic could be effective and that chiropractors were better trained to deal with musculoskeletal problems than most medical physicians."

The trial court also specifically found that:

"Even the AMA's economic witness, Mr. Lynk, assumed that chiropractors outperformed medical physicians in the treatment of certain conditions and he believed that was a reasonable assumption."

As these quotes indicate, diagnosis and treatment of NMS conditions is not within the expertise of the majority of medical physicians. Chiropractic physicians, on the other hand, receive extensive training in these areas and consequently, are recognized as experts. That is why a parallel gatekeeper system is so important. It not only will assure patients that they will receive proper evaluation and treatment, but it also serves as an important consumer protection.

The damage brought on by the lack of a "chiropractic gatekeeper" is evident in the current Medicare system. HMOs which contract with Medicare have been required by law to provide chiropractic benefits since 1973. And yet, it is extremely rare for a beneficiary's request for chiropractic services to be honored by a Medicare HMO. Instead, they must go outside the system to receive these benefits at their own expense. Apparently, as far as the HMOs are concerned, the law doesn't matter. As is clear, this type of gatekeeper system simply does not work. When biases are present, the inertia is profound.

(In a lawsuit now pending in Minneapolis, Minnesota, it appears that for several years Medicare HMOs have stonewalled all requests to reveal whether they have ever supplied chiropractic care. The HMOs, and the former Secretary of Health & Human Services, maintained that no record keeping was required to determine whether these benefits have ever been supplied. Given this level of recalcitrance, it appears the chiropractic profession and its patients are faced with spending millions of dollars in litigation costs merely to receive a Medicare HMO referral for care that Congress has mandated.)

Managed competition, or any system overly reliant on managed care-type entities, has the potential for failing to meet the very goals it sets for itself. If such a plan perpetuates the "old boys club" approach to health care, the well-known ingenuity of the current system will protect its own, neglecting or failing to truly provide appropriate oversight to the preservation of that which is good in the current system and continuing to embrace many of the sacred cows which add unnecessary costs to the system.

These facts are not intended to question medical gatekeepers' qualifications to evaluate and screen health care problems of a type other than neuromusculoskeletal. However, their lack of ability in that area is evidenced by the fact that there were 80,000 unnecessary spinal disc operations in 1991; that lumbar spinal fusions are widely performed each year with a tragically high percentage of poor outcomes; and that these

operations are performed without a single randomized controlled clinical trial ever having been conducted to show any value for the procedure.

Consider the following findings from a recent edition of the *Journal of the American Medical Association*.

- Of 47 articles reviewed there were no randomized trials.
- The indication for fusion in many lumbar spine disorders is not scientifically established.
- Also the lack of studies comparing spinal fusion with other surgical and nonsurgical treatments, or with no treatment, renders it impossible to determine the extent to which patient status at follow-up is due to the fusion.
- In sum, the literature does not definitively answer the questions we posed, and the statement made over a decade ago that "the literature on spinal fusion is totally inadequate" remains true today.<sup>19</sup>

In contrast, the chiropractic profession can refer to myriad studies, including those referenced earlier in this testimony.

#### Medicare Benefits Model

ACA is aware, Mr. Chairman, that you have proposed a benefits package patterned after the existing Medicare program. While we do not pass judgment on other aspects of the Medicare benefits model, that portion which relates to chiropractic services is wholly inadequate and cannot be supported by the chiropractic profession. However, with relatively minor changes to the wording of the Medicare statute, the ACA may be in a position to support such a proposal.

Over the years, you have graciously listened to our objections and suggested solutions regarding chiropractic coverage under the Medicare benefits model. We know that you understand our concerns. However, the problem has yet to be satisfactorily addressed. As a consequence, we feel that it bears repeating for the edification of the other members of the subcommittee.

The sole chiropractic benefit covered under Medicare is "manual manipulation of the spine."<sup>20</sup> This limitation denies beneficiaries access to the vast majority of services that DCs are licensed to perform under state law. Consequently, beneficiaries are required to pay for most chiropractic services out of pocket, despite the fact that these same

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<sup>19</sup> "Patient Outcomes After Lumbar Spinal Fusion," *JAMA*, Vol. 268, No. 7, August 19, 1992.

<sup>20</sup> 42 U.S.C. Sect. 1395x(r)(5).

services would be covered if performed by another, non-chiropractic Medicare provider.

Unfortunately, the charade doesn't end there. In order to receive reimbursement for the single chiropractic service Medicare covers, patients must have a spinal x-ray performed to document treatment necessity. However, in an example of twisted bureaucratic logic, if the Medicare-required x-ray is performed by a DC, it is not considered a covered service despite the fact that every state licenses DCs to perform x-rays. This policy erects an economic barrier to chiropractic care and has the effect of channeling patients away from DCs to other providers. And, as the federal judge in the Wilk case opined, it results in a "preposterous situation."

To add to these difficulties, the Medicare system has placed an arbitrary 12 visit cap on chiropractic care. (It is called a "screen", but since more than twelve visits are rarely covered, it is essentially a cap.) The arbitrary cap continues as Medicare policy, in spite of the fact that both the Guidelines for Chiropractic Quality Assurance and Practice Parameters (The Mercy Center Guidelines) and the North American Spine Society state that 42 and 38 visits, respectively, are indicated for uncomplicated chronic severe musculoskeletal functional disorders.

Given the absurd nature of Medicare's chiropractic benefit, it should come as no surprise that it was enacted in the early 1970s -- a time when the AMA's boycott of chiropractic and its influence over federal health care policy was at its height. It is clearly a vestige of a time when organized medicine was bent on destroying this profession and monopolizing health care.

That is why, Mr. Chairman, the Medicare benefits model is so repulsive to my profession. It is representative of the worst time in our profession's history -- and the worst of which the health care system is capable.

Chiropractic patients need access to the full spectrum of chiropractic's cost effective neuromusculoskeletal care. Diagnostic procedures, including diagnostic imaging, as well as supportive ancillary and physiotherapeutic treatment, should all be incorporated into Medicare before its benefits package is expanded to cover the entire population. In other words, if its benefits were expanded to include the services DCs are licensed to perform under State law, it is possible that the ACA could support "Medicare for all".

## CONCLUSION

The chiropractic profession spent over \$5 million bringing the AMA boycott to an end. It took the federal anti-trust laws, racketeering laws and fifteen years to do it. We give this testimony with great trepidation because of our bitter experiences with Medicare and other federal health programs over the past twenty years. My profession was targeted -- through the illegal boycott -- for complete "containment, isolation and elimination." We cannot fully put this unfortunate chapter in our profession's history behind us until we have some assurance that health care reform will not continue the isolation. To place medical gatekeepers between us, our patients and prospective patients

is not just to place the fox in charge of the henhouse but to invite the fox to devour the hen.

We look to Congress to help break the log jam, to break the monopoly, to establish true competition in the health care marketplace, to make sure that effective care finds its way into the system and ineffective care is shown the exit. All providers must meet the test. We believe we have done so. We are prepared to assist in the process and not to act as spoilers as health care reform unfolds.



Mr. ANDREWS. Thank you.  
Dr. Clum.

**STATEMENT OF GERARD W. CLUM, D.C., PRESIDENT, LIFE CHIROPRACTIC COLLEGE WEST, SAN LORENZO, CALIF., ON BEHALF OF THE INTERNATIONAL CHIROPRACTORS ASSOCIATION**

Dr. CLUM. Thank you, Mr. Chairman.

It is my pleasure to be here today and I thank you for the opportunity to speak to the committee.

As a doctor of chiropractic and president of Life Chiropractic College West, as well as president of the Association of Chiropractic Colleges, I would like to express concerns on behalf of the chiropractic profession, as we enter this new era of health care development.

I would like to take the opportunity to present the views of the International Chiropractors Association, to share our members' perspective on the challenging question of which benefits and services should be covered in the developing national health care system.

As Dr. McAndrews pointed out, the history of chiropractic care, the efficacy of chiropractic care and the efficiency of that care on a patient level is incontrovertible. What I would like to point out to you today is in relationship to the development of a new system. We are all well aware of the magnitude of such things as cancer and heart disease, but sometimes it is quite easy to overlook the impact of neuromusculoskeletal problems such as we are referencing today.

The Nation spends in excess of \$60 billion a year with problems of this nature. The chiropractic profession has proven itself to be capable of dealing with these problems on a cost-efficient basis, on a time-efficient basis and with a level of efficiency that patients find very, very satisfactory.

As we look at the emergence of new systems, certainly your concerns must focus on the containment of costs, and must focus on the ability of the system to sustain itself in the long haul. Decisions regarding the implementation of chiropractic care are critical to the future of that system, because of the advances that chiropractic care could offer in terms of the management of these health care problems.

The other factor that has to be taken into consideration is the historical emphasis that the chiropractic profession has placed upon elements of prevention. We have been individuals who have focused on the responsibility of the person to take care of their health, to be the primary agents of their health and of their wellness. We have focused on the responsibility of the person to live an appropriate and healthy lifestyle, and in that fashion to help reduce the level of morbidity and mortality that the society as a whole experiences.

The influence of the chiropractic profession in the health delivery system can be a vital and invigorating one. We bring a paradigm and a perspective to the health care system that heretofore has not been adequately addressed. We bring a perspective on the management of musculoskeletal pain in particular neuromusculoskeletal

problems that has proven itself effective many, many times over in many situations.

The most exciting evidence that has recently come to bear has come from Australia, where it has been demonstrated that with low back pain patients, in particular, going to chiropractic health care providers, they are six times less likely to proceed to chronic care status.

For anyone who is knowledgeable of the costs associated with musculoskeletal pain, they are aware that 90 percent of the costs are consumed by 10 percent of the persons who move on to chronic states. If our ability to influence and reduce that by that level, to cause one person in six to go to this status, rather than six in six, the impact that we could have upon the system would be tremendous.

We encourage you to investigate the questions that are being brought to you today by the various professional associations. We encourage you to look at the issues that we think chiropractic could address in a straightforward fashion for the benefit of the system on a cost containment basis, as well as on an efficiency basis, for the system and for the patient who is the recipient of that care.

We appreciate the opportunity to be before you today and look forward to cooperating in any way possible to facilitate the goals of the committee.

I ask that my prepared statement be entered in the record as the formal presentation on behalf of the association.

Thank you, sir.

[The prepared statement follows:]

Statement by Dr. Gerard W. Clum  
April 22, 1993

Mr. Chairman and Members of the Subcommittee, I am pleased to have this opportunity to appear before you this morning on behalf of the International Chiropractors Association and the thousands of doctors and students of chiropractic who comprise our membership. For nearly 100 years, the chiropractic profession has provided safe, effective and clinically appropriate health care to tens of millions of Americans with a high degree of patient satisfaction. It is from this perspective that I comment on what will undoubtedly prove to be the most difficult element in any proposal to reform our national health care funding and delivery system, the issue of mandated minimum health care benefits. Those basic services to which all citizens are entitled and which federally sanctioned programs of health insurance would be obligated by law to provide will certainly become the operative standard for health coverage in the U.S. The history of health benefits administration has shown that what is intended to be a minimum floor of basic benefits very quickly congeals into a maximum, largely because of economic imperatives. Any health professional who provides patient care under Medicare can testify to the validity of this concern. Great care, therefore, must be taken to recognize the implications the establishment of such a package carries with it.

Some frank discussion as to the precise objectives of a minimum benefits package is perhaps in order. What is the list of minimum benefits intended to do? We hope the answer to this question will be that any list of minimum benefits is intended to guarantee beneficiaries under such plans timely access to a range of health care services and options sufficient to meet all basic health care needs, and to preserve patient choice and basic patient freedoms. The concern among providers, however, is that marginal health care systems will look to the minimum benefits concept as a rationing device, the primary objective of which is to control utilization and restrain costs. We at the International Chiropractors Association would be obliged to emphatically oppose any approach that would employ minimum benefits as a rationing device, and we believe we would not stand alone in that opposition.

Decisions on the benefits package become controversial because of the perceived financial implications inherent in each addition to the list of items health plans will be obligated to provide. Hence, the process could easily become driven by cost containment imperatives, making quality and timeliness of care secondary considerations. Another value that could easily be placed in jeopardy in this process is the fundamental freedom of individual beneficiaries to make basic health care choices. In a quest for cost-containment, beneficiaries under many existing programs have already been asked to trade elements of their basic patient rights in exchange for certain guarantees of cost controls. From the chiropractic perspective, it would be a public policy tragedy to impose a system that ignores or otherwise diminishes basic patient rights and freedom of choice in a quest for cost-containment, particularly since patient control over health care decision making is the best guarantee of quality.

The current climate is one of legitimate fear and uncertainty regarding health care costs. We in the chiropractic profession strongly share these concerns and support meaningful cost control initiatives that are based on fair and responsible principles. The process of limiting options and eliminating choices in the quest for cost-containment, however, strikes at the heart of the one element we believe can best address the issue and that is competition. The restriction of patient access to all but a limited core of medical services would have the net effect of establishing a provider monopoly. When patient rights to choose alternative care such as chiropractic or other comparable services are abridged, it is important to recognize that a highly cost-effective service such as chiropractic will be passed over and patients will be obliged to resort to more expensive medical services which may very well be their second choice.

In the process of evaluating the utility of health services, we believe there is absolutely no room for prejudice or artificial exclusivity. Policies that bypass services that are demonstrably capable of providing satisfactory clinical outcomes on a cost-effective basis are, quite simply, bad policies. We in the chiropractic profession are content to compete on the basis of clinical outcomes because we are confident that chiropractic services are not only cost-effective, but highly valid, as an overwhelming body of clinical data supports.



The issue of cost-effectiveness is the most significant element that compels the chiropractic profession to be present here today. Not only do we believe that access to chiropractic services is essential for the physical well being of the patient, we believe that access to chiropractic services is essential for the benefit of the system and its financial well being.

As the Congress considers these complex issues, we ask you to consider following facts.

- \* **Doctors of chiropractic provide cost-effective care.** Studies have consistently shown chiropractic to be a more cost-effective method of caring for neuro-musculo-skeletal conditions, thus offering significant cost-containment potential to our health care system. DCs are trained to employ conservative, early-intervention methods as an alternative to surgical utilization, drug therapy and other high-cost treatments with a high degree of efficiency and patient satisfaction.
- \* **Chiropractic services are in high demand.** Tens of millions of American consumers routinely opt for chiropractic services and this number is rapidly growing. In 1993, more than 30 million consumers will make chiropractic a regular part of their health care program, even though personal out-of-pocket expenditures may be entailed. If there is one primary health care profession that can point to private sector demand and to marketplace viability for economic validation, it is chiropractic. Every day, thousands of consumers decide to spend their own money for chiropractic services when traditional medical care is available to them through insurance or government programs at a more subsidized cost or at no cost at all. Consumers make this choice because of the unique benefits chiropractic has to offer.
- \* **Doctors of chiropractic provide clinically effective health care.** A growing body of research supports this fact. Detailed studies conducted according to the highest scientific standards, and published by organizations as diverse as the RAND Corporation and the British Medical Association, continue to show the clinical effectiveness of chiropractic care.
- \* **Chiropractic offers a significant alternative to traditional medicine.** A recent *New England Journal of Medicine* article affirmed that Americans made more visits to non-M.D. providers (425 million visits) than to all US primary care physicians (388 million visits). Expenditures associated with use of alternative therapy in 1990 amounted to approximately 13.7 billion dollars. The figure is comparable to the 12.8 billion dollars spent out-of-pocket annually for all hospitalization in the U.S. One out of three Americans routinely uses alternative health care.
- \* **Chiropractic is the second largest primary health care profession in the United States and the fastest growing primary care profession in the world.** There are approximately 50,000 DCs in active practice in the United States spread from rural areas to inner cities. More than 10,000 students are currently studying in chiropractic educational programs accredited by a federally-recognized body. Doctors of chiropractic have been licensed and recognized as primary providers for many decades in all 50 states, the District of Columbia and Puerto Rico.
- \* **Chiropractic is recognized by governmental health care programs.** Chiropractic is included in Medicare, Medicaid, Federal Employees Health Care Benefits Programs, Federal Workers' Compensation and all state workers' compensation programs. Chiropractic students are qualified to receive federal student loan assistance and DCs are authorized to be commissioned as health care officers in the U.S. Armed Forces.
- \* **Doctors of chiropractic receive extensive, demanding professional education on par with other primary health care providers.** To receive the degree of doctor of chiropractic, candidates must complete extensive undergraduate prerequisites and complete four years of resident, full-time instruction in an accredited program. Students are thoroughly trained in the appropriate use of sophisticated diagnostic technology including X-ray, laboratory procedures and other state-of-the-art investigative technologies. The capacity to fully evaluate the health care needs of the patient, including appropriate referrals to other health professionals when necessary, is an important objective of chiropractic education.



- \* **The chiropractic profession is an effective prevention resource.** Doctors of chiropractic receive extensive prevention training and are a highly appropriate resource to effectively intervene in matters of nutritional counseling; substance abuse education and prevention; weight control; smoking cessation; postural correction; work-place safety; stress management; ergonomic design; and injury prevention.
- \* **Doctors of Chiropractic care for a wide range of conditions particularly those related to the spine and adjacent structures.** Total direct and indirect costs of spinal injuries in this country exceed 60 billion dollars. The highest frequency use of alternative therapy listed was for those people with back problems (30% and the alternative most commonly chosen was chiropractic. It is less expensive and more effective to utilize spinal manipulation than traditional surgical procedures.

There is an unprecedented sense of crisis pervading the discussion and debate in our country regarding the future of our health care delivery system. The key issue in this discussion is the growing cost of health services and the alarming realization that even though we spend one tenth of our entire Gross National Product on health services, tens of millions of our citizens are left uninsured and without proper care.

Planning and preparing to confront such an obviously uncertain future in health care requires not only a look forward, but a critical, objective look back to see how we got to this point in the first place.

In our current system, something is obviously very wrong. We ask--how is it that other industrialized nations spend far less than we do per capita on health services for their people, and have healthier populations. The answer lies not in how much we spend, but how we spend it.

Our entire national health care system, as it is supported and funded through the public sector, is focused on crisis care. Our national research priorities are based on finding increasingly dramatic cures and our national promise to the consumer seems to be that no matter how dire the condition, our health care system will find some basis, whether chemical, surgical or technological, to intervene and save every life. This is a wonderful and noble goal, however, this approach is fraught with very serious problems, the first of which is its ultimate impossibility to fulfill. Secondly, it focuses the greater share of responsibility for maintaining health on the health care provider and our national system of supporting institutions, instead of the individual him or herself. A vivid example is Medicare's announcement sometime ago that the program will now cover adult liver transplants because this procedure has been proven effective in dealing with a long list of conditions, including alcoholic cirrhosis. The transplant option may indeed be an effective course of care, but where was our national health system when early education could have prevented the alcohol problem in the first place. Where was our national health system when effective treatment and counselling could have helped the patient deal with his or her addiction. The same can be said for smoking, drug abuse, improper nutrition, industrial work place safety, auto and mass transportation safety, and a thousand other areas. Prevention is the new frontier of health care. It is ICA's hope that the current debate on national health care reform will focus much needed attention in this direction and foster a new dramatic growth of efforts in prevention. It is our belief that a new class of prevention benefits and services needs to be invented and incorporated into the practices of all health care professionals. I do not suggest that attention be shifted away from intervention research or service delivery, but that a new investment in prevention and education will ultimately yield dramatic savings through the reduction in demand for dramatic as well as routine health services.

Until we change our thinking and alter our focus to deal with prevention, health maintenance, health education, patient responsibility, early detection, conservative care alternatives and other first line issues, making this kind of approach our primary health care focus, nothing can or will change.

From the perspective of the chiropractic profession, spending more and more money in an endless pursuit of dramatic intervention at a stage in the patient's health in which the maximum amount of scarce resources will be required to obtain a favorable outcome, at the expense of prevention, education and factors such as this, is not always in the public interest, either economically or in terms of health policy.

The solution to our national health crisis, economically and in terms of demand lies in the hands of those who are the front line soldiers in the struggle against disease, and for national wellness. Individual providers, from all disciplines are facing an ethical and moral calling to change current patterns of thinking, and change current patterns of practice. The nation cannot afford business as usual. The health care delivery system must lead in this effort to engineer basic changes in the way we do business. This must be done in the national interest, not in self interest. In this effort, the chiropractic profession is an interested and willing partner.

- end -

Mr. ANDREWS. Thank you very much for your testimony, Dr. Clum.

Ms. Kienle.

**STATEMENT OF PATRICIA C. KIENLE, BOARD MEMBER, AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, AND DIRECTOR, PHARMACY SERVICES, MERCY HOSPITAL, WILKES-BARRE, PA., ON BEHALF OF THE COALITION FOR CONSUMER ACCESS TO PHARMACEUTICAL CARE**

Ms. KIENLE. Mr. Chairman, thank you.

I ask that a copy of my prepared testimony be included in the record, along with a copy of "Value of Community Pharmacists' Interventions to Correct Prescribing Errors," by Michael T. Rupp, Ph.D., appearing in the December 1992 Annals of Pharmacotherapy.

My name is Patricia Kienle. I am a pharmacist and the director of pharmacy services at Mercy Hospital, a nonprofit 228-bed acute care facility operated by the Religious Sisters of Mercy and located in Wilkes-Barre, Pa.

I am a member-elect of the board of directors of the American Society of Hospital Pharmacists and am today representing the Coalition for Consumer Access to Pharmaceutical Care.

The organizations in the coalition are identified in my prepared statement. They are united in their commitment to maximize the benefits that consumers receive from their medications and from their pharmacists.

I do want to recognize the Chairman, Mr. Stark, for his strong leadership in support of an outpatient drug benefit for all Americans. He has been a tireless advocate of allowing more Americans to take advantage of the professional services that pharmacists offer, including drug utilization review and patient counseling.

Our coalition has endorsed four principles fundamental to the organization and delivery of pharmaceutical care within a reformed health care system: one, pharmaceutical products and pharmaceutical care, that is pharmacists' services, should be included as a benefit under health care reform; two, pharmacists' services and the proper management of medications can generate significant savings, both in terms of cost and effectiveness, in a reformed health care system; three, quality assurance programs administered by pharmacists can significantly improve the effectiveness of medications; and four, integrated information systems that include pharmacists offer the potential for cost savings and better patient outcomes.

We support an integrated community-based primary health care delivery system that encourages pharmacists' collaboration with physicians and other health care professionals on medication issues. We also believe pharmaceutical care must be further coordinated among health care professionals as the patient moves along the ambulatory, institutional and home care settings.

Unfortunately, current State and Federal regulations hinder Americans from making better use of their medications and pharmacy services. We urge that all health benefits programs, private and governmental, develop incentives for pharmacists to use their professional judgment to enhance drug therapy.

Existing health insurance plans and much of what we hear from the Clinton administration focuses on a pharmaceutical benefit that is limited to the drug product. That is not enough.

In addition to the drug product, a comprehensive pharmaceutical care benefit must include: First, drug regimen review by the pharmacist to insure appropriate drug use and to minimize the likelihood of drug interactions and adverse reactions; second, personalized drug information by the pharmacist to promote patient understanding and compliance with therapy; third, a continuing system of drug utilization review conducted by the health plan for its enrollees; and, fourth, the development of drug formulary management systems.

Patients will be safer, medication use will be more effective, and overall health care costs will be reduced, when such pharmacy services are used.

Additional pharmacist services that some health care plans have found valuable include pharmacists management of drug therapy under protocols developed jointly with physicians, carrying out certain preventive health services in underserved areas, and a case management system for patients taking high risk and/or high-cost drugs.

Here is another important point: The existing product-based reimbursement approach for outpatient drug coverage should be replaced with one that takes into account pharmacists' effort and patient outcomes.

We believe Congress and the administration have a unique opportunity to help patients use medications safely and effectively by taking fullest advantage of the expertise that pharmacists have to offer.

Thank you, and I would be happy to respond to your questions.  
[The prepared statement and attachment follow:]



## TESTIMONY OF PATRICIA C. KIENLE

### Coalition for Consumer Access to Pharmaceutical Care

Mr. Chairman, my name is Patricia C. Kienle. I am a pharmacist and the Director of Pharmacy Services at Mercy Hospital, a non-profit, 228-bed acute care facility, operated by the Religious Sisters of Mercy, located in Wilkes-Barre, PA. I am a member-elect of the Board of Directors of the American Society of Hospital Pharmacists (ASHP) and am representing the Coalition for Consumer Access to Pharmaceutical Care (CCAPC). This Coalition represents pharmacists in every setting, including those who practice in the retail or community environment, in health care institutions and systems, and in education.

The membership of the Coalition consists of the Academy of Managed Care Pharmacy, the American Association of Colleges of Pharmacy, the American College of Clinical Pharmacy, the American Pharmaceutical Association, the American Society of Consultant Pharmacists, the National Pharmaceutical Association, and ASHP.

The members of the Coalition are committed to maximizing the benefit that consumers receive from their medications and pharmacists.

#### PRINCIPLES OF PHARMACEUTICAL CARE

Our Coalition, and nearly 50 other state and national pharmacy organizations, is united in its endorsement of the following four principles fundamental to the organization and delivery of pharmaceutical care under a reformed health care system:

- Pharmaceutical products and pharmaceutical care (pharmacists' services) should be included as a core benefit under health care reform.
- Pharmacists' services and the proper management of medications can generate significant savings in a reformed health care system.
- Quality assurance programs administered by pharmacists can significantly improve the effectiveness of medications in achieving positive patient outcomes.
- Integrated information systems that include pharmacists offer the potential for cost savings and better patient outcomes.

We believe an integrated approach, coordinated among physicians, pharmacists and other health care professionals, allowing for the intervention of the pharmacist on issues pertaining to medications, is essential to obtaining those therapy outcomes that help a patient regain health and minimize waste of financial resources. Of equal importance, pharmaceutical care must be coordinated among health care professionals as the patient moves among the ambulatory, clinical and home care settings.

Pharmacists are prepared to join with patients and prescribers to improve medication use. Each year, a significant amount of money is spent for unnecessary drugs and inappropriately managed drug therapy. Patient noncompliance, adverse drug reactions and misprescribing result in many preventable hospitalizations, nursing home admissions and other wasteful services.

We estimate that at least \$36 billion could be saved annually by coordinated efforts to implement these principles, leading to improved patient compliance with drug regimens, reduced inappropriate drug use and related hospitalizations, and decreased preventable adverse effects and interactions.

#### STRATEGY FOR ACTION

We offer two strategies to alleviate current state and federal regulatory barriers preventing Americans from making better use of the medications and pharmacy services available to them. Specifically, we recommend that federal policy address two disincentives for appropriate interaction by pharmacists to improve patient therapy; namely the differences in state provisions pertaining to options for selecting generic products and the fee structures of Medicaid and other federal programs.

As a short-term strategy, we urge that federal programs contracting with pharmacists for prescription and/or nonprescription medications develop appropriate incentives for pharmacists to use their professional judgment to enhance quality outcomes of drug therapy. These incentives should:

1. increase the use of generic pharmaceuticals, including a uniform method for prescribers to specify that a brand name medication is clinically necessary;
2. promote formulary systems, given the multiplicity and cost of pharmaceuticals;
3. encourage patient adherence to therapy; and
4. provide an exchange of information and promote collaboration among a patient's providers regardless of setting.

As part of the larger health care reform effort, we recommend that third-party administrators or pharmacy benefit managers help their beneficiaries to get the best use of their medications. To do this, the basic benefit package should incorporate coverage of pharmaceutical products and pharmacy services.

#### THE PHARMACEUTICAL BENEFIT

Covered pharmaceutical products should include all prescription drugs approved by the Food and Drug Administration. Coverage should be for any medically accepted indication approved by the FDA, or which is accepted within recognized drug compendia and/or peer-reviewed medical and pharmaceutical literature. Non-prescription drugs should be covered if prescribed by a physician or other authorized prescriber.

#### THE PHARMACEUTICAL CARE BENEFIT

The pharmaceutical care benefit should include four components. First, drug regimen review should provide an examination of the patient's drug therapy by the pharmacist. This would ensure appropriate drug use, minimize the potential for drug interactions and adverse reactions, and eliminate duplicate and unnecessary drug therapy.

Second would be providing personalized drug information to patients to promote their understanding and encourage their compliance with therapy. Information should be made available to other health care providers involved in the patient's care.

The third component of the pharmaceutical care benefit would be a continuing system of drug regimen review managed by the plan for the population served.

Fourth would be the development of drug formulary management systems that promote appropriate drug therapy, cost-effectiveness and pre-approved product interchanges.

Because it is so important that Americans have access to pharmaceutical products and services, health plans, third-party administrators and pharmacy benefit managers should be encouraged to develop utilization and participation standards that give qualified providers the opportunity to furnish these benefits.

#### FUTURE CONSIDERATIONS

The onset of systemic change in the delivery of health care services provides the opportunity for the consideration of additional pharmacists' services. One example would be pharmacist management of a patient's drug therapy under protocols developed jointly with physicians. Such protocols would include initial selection of therapy, following a physician's diagnosis, and monitoring patient response. Some protocols already exist for prescribing by pharmacists and other non-physicians.

A second would be the use of patient incentives to ensure compliance with therapy. These might provide for co-payments at the point-of-service, or differential co-payments for generic drugs. Other incentives would include patient education strategies and reminders to re-enforce the importance of following the physician's regimen.

A third option that could be considered is the delivery of preventive health care services by pharmacists, particularly in underserved areas where the health care infrastructure is weak or nonexistent. Such services might include chronic disease screening and therapeutic management and patient monitoring.

A fourth example, one with potential for almost immediate cost-savings, would be the development of a case management system for patients taking high-risk and/or high cost drugs or who are considered at risk owing to age, medical condition, family history or some other criterion.

#### REIMBURSEMENT

Pharmacists are prepared to join with prescribers and patients to improve medication use. We believe, however, the existing transaction-based reimbursement system currently used for outpatient prescription drug coverage should be replaced with a resource-based, outcomes-focused system of compensation for pharmacists' services.

Such systems would empower pharmacists to recommend or select the most cost-effective drug product to achieve the desired therapeutic outcome. These incentives would ensure that the drug regimen is effectively managed to assure patient compliance and minimize adverse effects.

Payments to pharmacists for providing pharmaceutical care should be based on health outcome parameters and include a return on capital investment and administrative costs. Under a reformed health care system, health plans should be authorized and encouraged to conduct studies testing new payment methodologies, including both intensity-based and risk-sharing cognitive services models.

#### DATA TRANSMITTAL

A pharmacy strategy for the future should focus on facilitating the movement of patient data to providers and plans. During the second year of the health care reform plan's existence, we recommend that it develop an automated patient information system that reflects medical and pharmaceutical care. This should include dispensed drugs, pharmacy services (including but not limited to, patient counseling, drug regimen review and drug therapy monitoring), along with associated product costs and professional service charges.

At a minimum, this system should electronically link the physician's office and the pharmacy for rapid transmittal of prescriptions, consultation, and pharmacy services. Patient health records should be linked with all appropriate health care providers to minimize drug interactions and identify conflicting and redundant care. (An addendum to this statement lists the patient data elements which support the delivery of pharmaceutical care.)

Once the data system is in place, health care plans should be required to enhance the system by making data on drug product use and prescribing patterns, therapeutic outcomes and adverse drug reactions available to physicians, pharmacists and other health care providers. Other reports could be prepared on medical and pharmaceutical services, utilization costs for drug product and non-product services within therapeutic categories and disease states, and on savings realized through appropriate management of pharmaceutical care.

#### CONCLUSION

The pharmacy profession has responded to changes in the nation's health care system brought about by innovative products with equally innovative services to improve patient care. Recently, new pharmacy services have focused on controlling medication-related costs through the development of systems to monitor and integrate cost-effective pharmaceutical care. The implementation of these systems has resulted in better patient care and reduced opportunity for health and life threatening events. We would be pleased to provide you with additional information and a refinement of the above ideas.

Many of these successful and cost effective systems provided by the pharmacy profession were developed, implemented and evaluated by my colleagues within institutional and managed care settings. The pharmacy profession is now at a stage of readiness where these same systems can be more widely applied to community care settings through the use of appropriate support systems, financial incentives and interdisciplinary communications.

Through the unfolding health care reform process, Congress and the Clinton administration are at the brink of a unique opportunity to apply a sound, cost-effective pharmaceutical care system nationwide. The Coalition for Consumer Access to Pharmaceutical Care urges you and your colleagues to seize the moment by implementing the four principles found within our testimony. Be assured of the pharmacy profession's commitment to help you meet the challenge of providing accessible, quality and cost effective health care to the American people.



## PHARMACOECONOMICS

Edited by William F. McGhan, J. Lyle Bootman,  
and Raymond J. Townsend

## VALUE OF COMMUNITY PHARMACISTS' INTERVENTIONS TO CORRECT PRESCRIBING ERRORS

Michael T. Rupp

**OBJECTIVE:** The purpose of this analysis was to estimate the economic value created by community pharmacists who routinely screen for and correct prescribing-related problems during the course of their dispensing activities.

**DESIGN:** Three expert judges evaluated the documented interventions of community pharmacists practicing in five states.

**RESULTS:** The judges agreed that 28.3 percent of the identified problems could have resulted in patient harm had the pharmacist not intervened to correct the problem. The direct cost of medical care that was avoided as a result of pharmacists' intervention activities was estimated to be \$122.98 per problematic prescription, or \$2.32 per each new prescription order that was screened during the study.

**CONCLUSIONS:** Clinical pharmacy services can and do create significant value by enhancing the achievement of positive patient outcomes and by avoiding negative outcomes. Research to develop reliable methods for measuring and monitoring the value of clinical pharmacy services must continue. Mechanisms must be created to encourage and reward pharmacists who consistently provide services that add measurable value to patient care.

*Ann Pharmacother* 1992;26:1580-4.

FROM JANUARY TO SEPTEMBER 1990, reactive interventions that were performed by community pharmacists to correct the prescribing-related problems they identified during the dispensing process were documented. Observations were performed at 89 community pharmacies in five states (Indiana, New Jersey, Ohio, Texas, and Washington) by specially trained observers over a total of 113 five-day observation intervals. (Some pharmacies had multiple observers during the study.)

MICHAEL T. RUPP, Ph.D., is an Associate Professor of Pharmacy Administration, Department of Pharmacy Practice, Purdue University, West Lafayette, IN 47907. Reprints: Michael T. Rupp, Ph.D.

This study was supported in part by a grant from the American Pharmaceutical Association (APhA) Foundation. Portions of this research were reported in *Prescribing Problems and Pharmacist Interventions in Community Practice: A Multicenter Study* (final report to sponsor, APhA Foundation, February 1991) and presented at the 138th annual meeting of the APhA, March 10, 1991, in New Orleans, LA.

WILLIAM F. MCGHAN, Pharm.D., Ph.D., is a Professor and the Executive Director, Institute for Pharmaceutical Economics, Philadelphia College of Pharmacy and Science, Philadelphia, PA; J. LYLE BOOTMAN, Ph.D., is a Professor and the Dean, College of Pharmacy, University of Arizona, Tucson, AZ 85721; RAYMOND J. TOWNSEND, Pharm.D., is the Vice President, Applied Healthcare Research, Glaxo Inc., Research Triangle Park, NC 27709.

Pharmacists in the study were primarily men (71.4 percent) with a median age of 38 years. All pharmacists held the baccalaureate degree in pharmacy as their only professional degree. Pharmacists' practice settings included 49 chain and 40 independently owned pharmacies.

Pharmacists intervened to resolve prescribing-related problems in 1.9 percent of the 33011 new prescription orders that were screened and dispensed during the study. Prescription orders that were insufficiently complete with respect to essential information (i.e., "errors of omission") accounted for 45.6 percent of all documented prescribing problems. Frank prescribing errors (i.e., "errors of commission") accounted for an additional 36.4 percent of problems that required pharmacist intervention. Remaining interventions were split between prescriptions that contained drug interaction problems (7.6 percent) and a broad category of other problems (10.4 percent), which included suspected fraud or abuse. A complete description of the prescribing problems and pharmacists' intervention activities that were documented during the study has been reported elsewhere.<sup>1</sup>

This article reports the results of an analysis to estimate the impact on patient health status of the interventions that pharmacists performed to correct the prescribing problems they identified. An indirect estimate is made of the value of pharmacists' intervention activities during the delivery of prescription drugs in the community practice setting.

### Methods

To estimate the potential impact on patient health of prescribing problems that were reported during the study, a panel of three judges evaluated the documented interventions. The two primary evaluators were a board-certified internist (M.D.) who had previously earned an undergraduate degree (B.S.) in pharmacy, and a clinical pharmacist (Pharm.D.) who had completed postdoctoral residencies in both pediatric pharmacy and clinical pharmacy practice. A third evaluator served as a tiebreaker for instances in which the two primary evaluators disagreed. This person was a Pharm.D.-trained clinical pharmacist and drug information specialist. Each of the three evaluators functioned independently from their counterparts.

For each intervention that pharmacists performed to correct prescribing problems, observers recorded the following information using a standard reporting format: (1) descriptive characteristics about the prescription order, the prescriber, and the patient; (2) a description of the intervention, including the nature of the problem, the actions taken by the

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pharmacist, and the names of all drugs involved, (3) all prescription medications that the patient was taking at the time of the intervention, (4) sources of information that the pharmacist consulted during the intervention, and (5) the outcomes of the intervention and the final disposition of the prescription.

## Results

For each documented intervention, the two primary evaluators completed an evaluation form (Appendix I). The evaluation form contained four questions. The purpose of the first question was to distinguish prescribing problems that could have resulted in patient harm in the absence of pharmacist intervention from those that could not. If, in the judges' opinion, adverse health consequences could not have resulted from the problem (i.e., "no"), then no further evaluation was performed. If the evaluator judged that the problem could have resulted in patient harm, then evaluation of the intervention continued to question 2 on the form.

### POTENTIAL FOR PATIENT HARM

Evaluators' responses to the first question, "Could this event have resulted in adverse health consequences to the patient if the pharmacist had not intervened?" are illustrated in Figure 1. Both primary evaluators responded "yes" for 128 of the 623 problematic new prescription orders (20.6 percent) in which pharmacists intervened during the study. In 414 instances (66.4 percent), both evaluators responded "no" to this question. Evaluators disagreed for the remaining 81 interventions (13 percent).

To measure the strength of agreement between the two primary evaluators, the Kappa statistic of agreement was calculated.<sup>2</sup> The value of Kappa was found to be 0.68, indicating that a moderately strong agreement existed between the two primary evaluators in their assessment of the potential for patient harm resulting from the documented prescribing problems.

The 81 interventions for which the two primary evaluators disagreed as to the potential for patient harm were subsequently submitted to the third evaluator. This evaluator judged that patient harm could have resulted in 48 (59 percent) instances, agreeing more often with the physician (79 percent) than with the other pharmacist (51 percent). Thus, for 176 interventions (28.3 percent), two of three expert evaluators agreed that the prescribing problem that necessitated pharmacist intervention could have caused harm to the patient had the pharmacist not corrected the problem. The value of Kappa for this agreement was calculated to be 0.88, indicating a relatively strong agreement among the three judges in their assessment of potential patient harm.

### TYPE OF PATIENT HARM

In question 2 of the evaluation, the judges were asked to specify the adverse health consequence that they considered most likely to have resulted from the documented prescribing problem in the absence of the pharmacist's intervention. Evaluators' assessments of the type of patient harm they expected to result from prescribing problems are summarized in Figure 2. The solid bars represent agreement between the two primary evaluators on the type of patient harm they expected to result from the 128 problems for which they agreed that patient harm was possible. The broken bars represent agreement by any two evalua-

		Pharmacist Evaluator					Pharmacist and Secondary Evaluator		
		No	Yes				No	Yes	
Physician Evaluator	No	66.4%	9.2%		Physician and Secondary Evaluator	No	66.4%	4.5%	
	Yes	3.8%	20.6% (n = 128)			Yes	0.8%	28.3% (n = 176)	
(n = 623)				Primary Evaluators	(n = 623)				All Evaluators

Figure 1. Possible patient harm from prescribing problems.

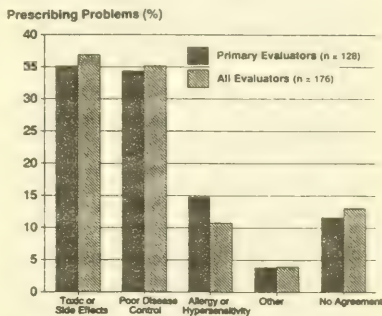


Figure 2. Type of harm expected from prescribing problems.

tors for the 176 interventions in which two of the three agreed that patient harm was possible.

The two distributions in Figure 2 are very similar. "Toxic or Side Effects" of the drugs involved and "Poor Disease Control" were the two types of patient harm that evaluators cited most frequently as anticipated consequences of the documented prescribing problem. "Allergy or Hypersensitivity" to the prescribed drug represented a distant third in terms of anticipated adverse patient health consequences. Among adverse health consequences classified as "Other" in Figure 2 were several instances in which harm was expected to a developing fetus or a nursing infant, rather than to the patient directly. Finally, there was no agreement between the two primary evaluators as to the type of harm expected from 15 of the 128 problems (11.7 percent) for which adverse patient health consequences were anticipated. Similarly, no agreement could be reached for 23 of the 176 prescribing problems (13.1 percent) that two of the three judges agreed were potentially harmful.

The Kappa value of agreement in question 2 was 0.82 between the two primary judges, and 0.79 among all three. These values indicate a strong agreement among evaluators on the type of patient harm that would be expected to result from potentially harmful prescribing problems.

### PROBABILITY OF PATIENT HARM

In question 3 of the evaluation, the judges were asked to estimate the probability that the patient harm they speci-

fied in question 2 actually would have occurred had the pharmacist not intervened to correct the prescribing problem.<sup>a</sup> Values of zero and one were included in the scale for anchoring purposes only. Evaluators were instructed to answer "no" to question 1 if they judged the probability of patient harm to approach zero.

The two primary evaluators were very similar (*t*-test,  $p > 0.05$ ) in their estimates of the probability that patient harm would have resulted from the 128 prescription orders for which they agreed that harm was possible: the physician evaluator assigned a mean probability of 0.783 (SD 0.180), and the clinical pharmacist assigned a mean probability of 0.776 (SD 0.135). Although not directly comparable, the third evaluator's mean assessment of probability that patient harm would have occurred was 0.617 (SD 0.169) for the additional 48 cases in which she agreed with one of the two primary evaluators that patient harm was possible.

#### MEDICAL CARE REQUIRED TO TREAT PATIENT HARM

In question 4 of the evaluation, the judges were instructed to estimate the intensity of medical care that would be required to treat the patient harm they had specified in question 2, assuming that it occurred. This was accomplished by selecting one of five responses reflecting different intensities of medical care. Thus, question 4 was intended to be an indirect measure of the severity of patient harm that may have resulted from the prescribing problem.

The two primary evaluators' estimates of the intensity of medical care required to treat the prescribing problems for which they and one of the other two evaluators agreed that patient harm was possible are summarized in Figure 3. Also illustrated in this figure are the third evaluator's responses for the 48 prescribing problems that she evaluated.

As the data in Figure 3 demonstrate, agreement between the two primary judges on question 4 of the evaluation was significantly lower than that obtained on the previous three questions. For example, the primary pharmacist evaluator estimated that 34.1 percent of the documented prescribing problems would have required emergency medical attention and subsequent hospitalization. In contrast, the physician evaluator selected this response for only 23.3 percent of the cases. The physician estimated that emergency medical attention alone would be required in 12.5 percent of the cases, yet the primary pharmacist evaluator selected this response for only 2.9 percent of problems. The two primary evaluators were similarly split in the proportion of prescribing problems for which they anticipated the need for urgent care or a scheduled office visit, 21 vs. 46, and 42.1 vs. 15.9 percent for the physician and pharmacist, respectively. Both primary evaluators estimated that 1.1 percent of prescribing problems for which patient harm was possible would have required only self-care.

#### Estimated Value of Pharmacists' Interventions

The estimated value of pharmacists' interventions was limited in the analysis to the projected direct costs of medi-

Problematic Prescriptions (%)

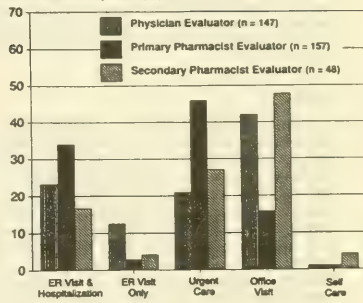


Figure 3. Medical care required to treat patient harm.

cal care that was avoided as a result of the pharmacists' actions. Not included in this estimate, although clearly relevant to prescribing errors and the costs of their negative sequelae, were costs attributable to losses in patient productivity, psychosocial costs of pain and suffering to patients or their families, and costs arising from possible litigation against physicians or pharmacists.

Estimates of the costs of medical care were made for each level of care in question 4 of the evaluation form using information from authoritative sources. For purposes of the analysis, the category "Self-Care" was assumed to be associated with no direct costs of medical care.

The most severe prescribing problems were those for which the judges anticipated the need for emergency medical attention followed by hospitalization of the patient. The cost of this level of care was estimated to be \$2001 and includes two components: an emergency room visit and a hospital stay. The cost of an emergency room visit was placed at \$110, based on the average hospital and physician charges for an emergency room visit requiring an intermediate level of service.<sup>b</sup> The cost of hospitalization was estimated to be \$1891. This estimate was based on an average adjusted cost of \$591 per day for a semiprivate room in a nongovernment, not-for-profit hospital<sup>c</sup> with a 3.2 day length-of-stay.<sup>d</sup>

The cost of the next level of care, an unscheduled physician contact (i.e., "urgent care"), was estimated to be \$60. This estimate was based on the average charge for a patient visit to a freestanding ambulatory care facility.<sup>e</sup> The cost of a scheduled physician office visit was estimated to be \$40. This estimate was based on the median fee charged to established patients by office-based physicians during

<sup>a</sup>For an explanation of subjective probability measurement and the psychometric research that has been done to link semantic terms with estimated probabilities, see Von Winterfeldt D, Edwards W. Uncertainty and its measurement. Cambridge: Cambridge University Press, 1986:90-136.

<sup>b</sup>Derived from analysis of insurance claims data provided by Lincoln National Administrative Services Corporation, Ft. Wayne, IN, February 1, 1991.

<sup>c</sup>Estimated hospital room cost derived from AHA Hospital Statistics, 1989-90, Chicago: American Hospital Association, 1989:13.

<sup>d</sup>Estimated length-of-stay was based on the mean length-of-stay for Medicare's diagnosis related group categories 447-451, which include allergic reactions and poisoning and toxic effects of drugs. For an explanation of this system, see Lorenz E, Jones M. The physician : DRG working guidebook, 1991. Alexandria, VA: St Anthony Publishing, 1990.

<sup>e</sup>From ACC Factor III. The Ambulatory Care Industry in 1990, a survey conducted for the National Association for Ambulatory Care by First Source Research, 1990.



the spring of 1990 for an office visit that required an intermediate level of service.<sup>3</sup>

Using the above valuation procedure, evaluators' estimates of the medical care required to treat patient harm were associated with an estimated cost of treatment. Two independent estimates of the cost of treating the adverse health consequences of prescribing problems were then calculated for each of the 176 new prescription orders for which two of the three evaluators agreed that patient harm was possible. These cost estimates were then multiplied by the evaluators' estimates of the probability that patient harm actually would have occurred in the absence of pharmacist intervention. This procedure generated two probability-adjusted estimates of the direct cost of medical care that was avoided because of the pharmacist's intervention for each of the 176 new prescription orders. The results of this analysis are summarized in Table 1.

The total mean estimated value of pharmacists' reactive interventions during the study was \$76 615. If distributed across the 623 problematic new prescription orders that required intervention, the mean estimated value created each time a pharmacist intervened to correct a prescribing-related problem was \$122.98. When the total value of pharmacists' interventions is distributed across all 33 011 new prescriptions that were screened and dispensed during the study, the mean value that pharmacists added to each new prescription order by screening for prescribing problems was estimated to be \$2.32.

### Discussion

As a result of efforts to contain the spiraling costs of healthcare, providers are increasingly being challenged to justify their role in the healthcare delivery system. In a recent editorial on this subject, Joseph A. Califano, former secretary of the Department of Health, Education, and Welfare, called for elimination of what he termed the "pharmacists' monopoly" over the distribution of prescription drugs. His rationale for this sweeping strategy was that "today, virtually all prescriptions can be filled by anyone who can read and count."<sup>4</sup>

The results of our analysis suggest that eliminating the pharmacist from the delivery of prescription drugs may be very shortsighted, both for ensuring the quality and safety of care, as well as for containing the costs of that care. The results of this and previous studies indicate that approximately 2 percent of new prescription orders in the community setting contain at least one prescribing-related problem that requires active intervention by the pharmacist to resolve. Of these, more than 28 percent are prescribing errors that are potentially injurious to patients if left undetected and uncorrected.<sup>5</sup>

If these estimates accurately reflect current prescribing practices in the community setting, then simply being able to "read and count" is clearly insufficient to fulfill the professional responsibilities associated with delivering prescription pharmaceutical care to consumers. Rather, the person who fills this role is—or at least should be—an essential provider of quality assurance in the delivery of safe and appropriate prescription care to consumers.

Evaluating any healthcare service is an indeterminate undertaking under the best of circumstances. Estimating the economic value created by an activity that may have

Table 1. Estimated Value of Pharmacists' Interventions<sup>a</sup>

	TOTAL VALUE	VALUE PER INTERVENTION <sup>b</sup>	VALUE PER Rx SCREENED <sup>c</sup>
Minimum	\$27 401	43.98	0.83
Mean	76 615	122.98	2.32
Maximum	125 828	201.97	3.81

Rx = prescription.

<sup>a</sup>Value refers to the estimated direct cost of medical care avoided because of pharmacists' interventions, and is represented in US dollars.

<sup>b</sup>n = 623.

<sup>c</sup>n = 33 011.

prevented some undesirable consequence from occurring is fraught with even greater uncertainty. Although researchers have used a variety of approaches to measure the impact, both clinical and economic, of clinical pharmacy services and related activities, no single approach has been widely embraced.<sup>6-10</sup> Still, decisions about pharmacists' clinical activities, their relative value, and the risk of eliminating them from the bundle of goods and services that make up contemporary healthcare, must—and will—be made.

In 1990, the Office of the Department of Health and Human Services Inspector General Richard P. Kusserow released a report titled *The Clinical Role of the Community Pharmacist*.<sup>11</sup> The objectives of the study upon which this report was based were: (1) to examine the current level of clinical services available in community pharmacy settings, (2) to identify barriers that limit the availability of such services, and (3) to suggest actions that can be taken to reduce barriers and improve pharmaceutical care for ambulatory patients.

Several conclusions of the Inspector General's report are particularly relevant to the analysis presented here. First, the report stated "there is strong evidence that clinical pharmacy services add value to patient care and reduce healthcare utilization costs." Second, despite this recognized potential, the report also observed that clinical services "are not widely provided in community pharmacy settings." Finally, the report concluded that "in the community pharmacy setting, significant barriers exist that limit the range of clinical services generally provided," one of the most formidable of which is a transaction-based reimbursement structure which links pharmacists' reimbursement "to the sale of a product rather than provision of services."<sup>11</sup>

Many consumers and financiers of prescription healthcare would suggest that screening, drug therapy monitoring, and related extradistributive clinical activities are inseparable parts of prescription drug delivery. They argue, therefore, that these services are not legitimately disaggregated from the distributive activities associated with drug delivery. Indeed, most pharmacists would probably agree that screening prescription orders for errors is a professional responsibility of every pharmacist to every patient.

Despite this philosophical consensus, however, the degree to which prescription screening and related clinical activities actually are performed by those involved in prescription drug distribution, particularly in the community setting, varies tremendously between different drug-delivery systems, and even among different pharmacy practices.<sup>4</sup> Thus, these "value-added" clinical services are still largely discretionary in the community setting in practice, if perhaps not in principle.



## Summary

Available evidence strongly suggests that many clinical pharmacy services can, if performed competently and consistently, create significant value by enhancing the achievement of positive patient outcomes and/or by avoiding negative outcomes. Nevertheless, much of the evidence in support of the value of clinical pharmacy services is still preliminary, and widely accepted methods for measuring this value remain elusive. Once such methods are widely available, this value can be measured and monitored by consumers and payers to ensure that sufficient value is being created to justify exchanging value (i.e., paying) for the services. Where the value of clinical pharmacy services can be clearly demonstrated, mechanisms can be, and should be, created to encourage and reward pharmacists who consistently perform these services, and to distinguish them from those who do not.  $\square$

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## EXTRACTO

**OBJETIVO:** El propósito de este análisis es estimar el valor económico creado por los farmacéuticos de comunidad, quienes rutinariamente manejan y verifican problemas relacionados a actividades de prescripción diarias.

**DISEÑO:** Tres jueces expertos evaluaron las intervenciones documentadas de farmacéuticos de comunidad que practican en cinco estados.

**RESULTADOS:** Los jueces concluyeron que 28.3 por ciento de los problemas que fueron identificados pudieron resultar en daños a pacientes si el farmacéutico no hubiese intervenido en corregir el problema. El costo directo de cuidado médico que se evitó como consecuencia de la intervención del farmacéutico fue estimado en \$122.98 por cada problema relacionado a una prescripción, ó \$2.32 por cada nueva prescripción que fue evaluada durante el estudio.

**CONCLUSIONES:** Los servicios ofrecidos por la farmacia clínica pueden y están creando un valor significativo aumentando la probabilidad de éxito en la terapia indicada por el médico, así como evitando resultados

## Appendix I. Pharmacist Intervention Report Evaluation

EVENT I.D. \_\_\_\_\_ EVALUATOR I.D. \_\_\_\_\_

- Could this event have resulted in adverse health consequences to the patient if the pharmacist had not intervened? (check one)
  - ☐ no (if no, stop here) ☐ yes (if yes, please continue)
- What adverse health consequence do you consider most likely to have resulted from this event if the pharmacist had not intervened? (check one)
  - ☐ toxic or side effects of the drug(s) involved
  - ☐ inadequate control of patient's condition
  - ☐ allergy/hypersensitivity reaction
  - ☐ other (specify) \_\_\_\_\_
- Based on the available information, what is your estimate of the probability that this event would have resulted in the adverse health consequence specified above? (circle one)

	Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely	
0	0.1	0.3	0.5	0.7	0.9	1.0

- What intensity of healthcare would be needed to treat the adverse health consequence specified above, assuming that it did occur? (check one)

- ☐ emergency medical attention (hospitalization likely)
- ☐ emergency medical attention (hospitalization unlikely)
- ☐ unscheduled physician contact (urgent care)
- ☐ scheduled physician contact (office visit)
- ☐ self-care (specify) \_\_\_\_\_

Comments: \_\_\_\_\_

I.D. = identification.

negativos innecesarios. Las investigaciones en desarrollar métodos confiables para medir y evaluar el valor de los servicios de la farmacia clínica deben continuar. Se deben crear mecanismos para estimular y recompensar a aquellos farmacéuticos que consistentemente proveen servicios que añaden un valor significativo al cuidado de pacientes.

DAISY RIVERA DE ALMENTERO

## RESUME

**OBJECTIF:** L'objectif de cette étude était d'estimer la valeur économique des interventions des pharmaciens communautaires qui évaluent les problèmes reliés à la prescription et qui les corrigent de manière routinière pendant leurs activités normales de distribution.

**DEVS EXPERIMENTAL:** Les interventions écrites des pharmaciens communautaires travaillant dans cinq états furent évaluées par trois juges experts.

**RESULTATS:** Les juges étaient d'accord pour dire que 28.3 pour cent des problèmes identifiés auraient pu être dommageables pour le patient si le pharmacien n'était pas intervenu pour corriger ledit problème. Les coûts directs des soins médicaux qui furent évités par les interventions des pharmaciens furent évalués à \$122.98 par prescription problème, ou \$2.32 pour chaque nouvelle prescription évaluée durant l'étude.

**CONCLUSIONS:** Les services cliniques pharmaceutiques se révèlent être très utiles pour améliorer la qualité de vie des patients et aussi pour leur éviter des problèmes potentiels. Des études ayant pour but de développer des méthodes fiables pour mesurer et monitorer la valeur des services cliniques pharmaceutiques doivent continuer à s'effectuer. Des mécanismes doivent être créés pour encourager et récompenser les pharmaciens qui offrent constamment des services qui améliorent la qualité des soins médicaux des patients.

PIERRE DION

Mr. ANDREWS. I only have one question for the whole panel, and it is what we discussed a couple of panels ago. I am curious what your thoughts are about who should be ultimately making these decisions as to who and what goes into a basic package.

Chairman Stark and I disagree on some parts of this proposal, yet we agree on others. One of the things that we discussed, as members of the subcommittee, is really who should make the decision, either the Congress or some national board. I favor a national board. I am curious what your thoughts are and why.

Dr. McAndrews, would you like to have a shot at that?

Dr. MCANDREWS. Yes, I would. It seems to me that the Congress needs to be the primary controller of such activities. Of course, from a—

Mr. ANDREWS. Why do you say that? Are you afraid that you will be excluded, if Congress is not involved?

Dr. MCANDREWS. No. I think what was in my mind there was a little more fundamental, that the representatives of the people more directly would have something to say about it. I am rather pleased myself at the way the process is unfolding right now, that a lot of experts free from many of the political pressures are able to put together some in-depth thought and then bring it to the Congress.

A national health care board would be an extremely powerful and influential element, almost—

Mr. ANDREWS. So is the Congress, but are we in a position to be experts on health care decisions, as 435 members of Congress, of what cost effectively ought to be in a basic plan? Are we more so than some blue ribbon panel that we might choose?

Dr. MCANDREWS. It is possible that the sub-boards to the national health board would handle some of the concerns that I would have, for example, the data standards board. My association, as I testified, had some 26 randomized control trials in the last 6 years on the effectiveness of our care. It is so easy to take my profession's studies and ignore them, because of our past difficulties, our not having yet emerged into the mainstream of health delivery.

And so I am concerned that a data standards board has some very stringent requirements for consideration of valid studies submitted to it, that it must respond within a specific period of time as to whether or not it will recognize that study, that it has been published in a refereed scientific journal, and that it is now going to be integrated into the minimum benefits package for use in the health care reform system.

So I am concerned about getting lost in the overall controlling mechanism and I don't—

Mr. ANDREWS. Isn't there a general concern, a genuine concern that if we leave it just up to Congress, that politics will play too great a role? For instance, as I mentioned earlier, I have a major chiropractic college in my district. I am proud of that. There are a lot of my constituents that are chiropractors.

But isn't there a concern that an individual member of Congress will be making these health care decisions not based on cost-effectiveness or health care or long-range planning for what ought to go into the package on the merits, but more who his constituents are and who is from his particular district and regional issues that



may or may not have—the chances are they don't have a great deal to do with sort of the overall health care goals that health care reform ought to take?

Dr. MCANDREWS. I empathize with that, because I feel everyone is a victim of health care, that everyone is vulnerable to it, because its language is so difficult to deal with and to track. It is not like caveat emptor, let the buyer beware. If you buy a bad automobile, you are just out cash. But if you buy an unnecessary surgery, you are out of a quality of life forever, and these decisions must be dealt with by experts, but ones that have very strong oversight, because that type of—even peer review has been proven to be so misused in our history.

Mr. ANDREWS. Does anybody else want to add? Dr. Finn.

Ms. FINN. The American Dietetic Association does not have a particular opinion on who makes that decision and we really realize what a very difficult job this is and applaud this committee, Congressman Stark, for your work in helping to look at this basic benefits package.

We feel very strongly, however, whoever makes that decision, they must recognize the value that nutrition services and nutrition science—

Mr. ANDREWS. I understand you feel that way, and I appreciate that and that was the gravamen of your testimony and it was excellent. But my question really is not whether you ought to be included or not. But the process that we should start over the next several months in deciding who and what should be in this package is an awfully important one, and I agree with that, and surely there should be a great deal of oversight.

I guess the query that I am trying to make to you is who is in the best position, the one that is the freest of political pressures or constituent pressures and more interested in trying to come up with a real package that services Americans and moves us in a direction that is cost-effective and makes sure everybody gets covered.

Dr. Tinkelman, do you want to comment?

Dr. TINKELMAN. I believe this is a very complex issue. I also suggest it be an independent board that has input into the decision that is made, recognizing that this issue impacts people at all different levels, so that you would have physicians, nonphysicians, insurance agents, as well as the people who hold the corporate strings, which is actually members of Congress.

So I believe that everyone who sits on that panel, whether they truly believe themselves independent or not, comes with a certain set of bias, perhaps, that is responsive to whoever has put them in that position. So I believe if all these interests or many of these interests can be brought together into a board and thrashed out, a policy can be determine which would be equitable. Certainly, any policy that you establish, sir, is not going to please everyone, and I believe that is a very difficult task facing the American government at this time, as well as the American people.

Mr. ANDREWS. Dr. Clum.

Dr. CLUM. I would speak to the responsibility remaining with Congress, rather than moving to a board. No matter how this is structured, the participants in the board will bring prejudices, will

bring professional experience, will bring professional biases, will bring all sorts of information and baggage with them. They will certainly try to make as unfettered a decision as possible and as clean and as true a decision as possible.

But the Congress has access to those people, as well. You have the ability to draw on experts, you have the ability to draw upon people for counsel and for input, and then you make the decision on behalf of the system involved, in fact the country is going to pay for and the people are going to pay for.

I don't think that we would be well-served by a Federal Reserve Board of Health Care that would set up a structure that would be so immune, that it would not be responsive to the parties that are involved. You know better than I at this point that the vast array of people that are involved in health care, the views that have to be taken into consideration and the elements that have to go into that.

As an individual, certainly, I am going to lobby from a chiropractic perspective. Everyone has their own viewpoint. We need someone with a larger context. The thought that comes to mind is a quote from Fr. Timothy Healy. Father Healy talked, in counseling presidents of colleges, that everybody had the responsibility to argue for their department and the president had the responsibility to see the greater picture.

All of us as providers argue for what we feel is in the best interest of the patient. What we expect and we look to Congress to do is to make the decision as to what is best for the people in a generic sense. In closing, I would simply say that, from our perspective, we see that it is best left with Congress to make the decision, with adequate input from as many different resources as you feel are necessary to make that decision.

Mr. ANDREWS. Thank you all very much. It has been an excellent panel and I appreciate your testimony.

Mr. KLECZKA [presiding]. I turn to my colleague Congressman McNulty of New York to introduce our late arrival who was supposed to be with the last panel and has arrived now and will be part of the panel we are going to introduce shortly.

Congressman McNulty.

Mr. McNULTY. Thank you, Mr. Chairman.

I want to welcome all of the members of the panel, but especially my constituent from the Albany Medical Center, Dr. David Cornell.

Mr. Chairman, as you know, I am one of the newer members of the Ways and Means Committee, and in recent months I have been attempting to get up to speed on all of the major issues we are going to discuss this year, and perhaps the most complex of those is health care reform. One of my teachers has been David Cornell, and I am deeply grateful for the expertise that he has shared with me up to this point. And I am grateful to you, Mr. Chairman, for giving him the opportunity to address us here in Washington, so that other members of this panel and the Ways and Means Committee generally and the U.S. Congress can have the benefit of his expertise.

Thanks very much, Mr. Chairman, for allowing me to greet him this afternoon.

Mr. KLECZKA. Thank you, Mike.



I also welcome Dr. Cornell. Better late than never, sir. We will start out with you, Dr. Cornell.

**STATEMENT OF DAVID R. CORNELL, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALBANY MEDICAL CENTER, ALBANY, N.Y.**

Dr. CORNELL. Thank you, Congressman. I apologize for some unfortunate travel arrangements, but I am glad to be here and am glad to participate in this proceeding.

My name is Dr. David Cornell, president and chief executive officer of the Albany Medical Center in Albany, New York. The Albany Medical Center includes as 671-bed hospital serving northeastern New York State and the Albany Medical College.

Like most academic medical centers, we play a special role in the community. Hospitals throughout northeastern New York refer their most difficult cases to the medical center. The faculty of the medical college and resident training are at the center and are a resource to hospitals and physicians throughout our area.

Within the next several weeks, the President's Health Care Task Force will make its recommendations. While I will not speculate what will be the report of the task force, it seems that a standard or uniform benefits package must be an essential element of its proposal.

I will address three issues. First, why do we need a uniform benefits package? I will approach this question not from the broad policy perspective of how does it fit into this week's version of managed competition, but what does a uniform benefits package mean for patients and for health care providers. Second, should medical education be part of any standards benefits plan? And third, should a standard benefits plan be uniform? Should there be exemptions?

Why a basic benefits plan: Will a uniform or standard benefits package make it easier for the consumer? The answer is maybe. Lest you think that I see our patients as no more than customers, I should define what I mean by a consumer or customer. When I buy health insurance, I am a consumer. When I receive health care services, I am a patient. Those of us who provide health care services believe that our responsibility to the patient far exceeds the responsibility most businesses have to their customers. It is a different relationship.

In theory, a standard benefits package allows the consumer to make rational economic decisions. It allows the consumer to plainly see what services are covered and what are not covered. Health economists tell us that consumers are unable to compare the value of competing health insurance plans, because there are hundreds of different plans on the market, each with a different set of benefits. How do we compare the value of a copayment on physician services in one plan to a limit on the number of mental health visits covered by another plan?

Consumers must choose not only between different benefit packages, but between different types of plans. The consumer must choose between traditional indemnity plans, staff model HMO's, preferred provider organizations, independent practice associations, and an almost infinite number of variations of these models.

Each insurance plan also has its own schedule of out-of-pocket expenses. There are different levels of copayments and deductibles. Many employers require the employee to pay part of the cost of health insurance premiums. There are also the intangible elements, such as the number of forms the consumer turned patient must fill out or the type of service the patient receives when he or she calls the insurance plan. I call this the convenience factor.

This committee must address more than the standard benefits package. This committee must also look at whether there should be differences in copayment and deductibles or employee contributions or in the types of forms patients must fill out and submit.

A standard benefits package will make the patient's life easier. Trying to determine what is covered and what is not covered can only be characterized as a nightmare. You can begin to imagine the scope of the problem based on the amount of mail each of your offices receives every day from Medicare beneficiaries and others in the community pleading for some help in understanding what their health insurance covers. A standard benefits package will eliminate much of this confusion.

A uniform benefits package has a very practical, although mundane, benefit for providers of health care services. The problems hospitals face billing health insurance plans is not very exciting and pales in comparison to the many important topics discussed before this committee. It is how we stay in business, caring for patients. For providers of health care, the benefit package tells us which services are covered and how to bill the health insurance plan.

At a time when computers should handle most patients' bills, it often takes our patient accounting staff hours to manually match the payments from a patient's insurance plan to the patient's bill. There are over 10,000 health insurance plans in New York State alone. Ninety percent of our patients are covered by one of several health insurance plans, namely, Medicare, Medicaid or Blue Cross, or one of the large regional health maintenance organizations. It is relatively easier for hospitals to bill one of these major insurance plans and, for the most part, the billing process is automated.

Billing for those covered by the thousands of other health insurance plans is an administrative quagmire. Matching a hospital's bill to a particular benefit package and the particular rules and idiosyncracies governing each of these plans is very time consuming.

Mr. KLECZKA. Doctor, if I could interrupt at this point, I am going to ask you to possibly summarize, knowing full well that your statement—

Dr. CORNELL. Yes, sir, I am watching the lights.

I think the most important thing I would like to summarize is that medical education is an absolute benefit to all people in the country and should be funded and governed under any particular health reform package that comes out. I think that would be the most important point that I would leave with you today.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF DAVID CORNELL**  
**Albany Medical Center, Albany, N.Y.**

My name is Dr. David Cornell, President and Chief Executive Officer of the Albany Medical Center in Albany, New York. The Albany Medical Center includes a 671-bed hospital serving Northeastern New York State and the Albany Medical College. Like most academic medical centers, we play a special role in the community. Hospitals throughout Northeastern New York refer their most difficult cases to the Medical Center. The faculty of the Medical College and resident training at the Center are a resource to hospitals and physicians throughout our area.

Within the next several weeks, the President's Health Care Task Force will make its recommendations. While I will not speculate what will be in the report of the Task Force, it seems that a standard or uniform benefit package must be an essential element of its proposal.

I will address three issues. First, why do we need a uniform benefit package. I will approach this question not from the broad policy perspective of how does it fit into this week's version of managed competition, but what does a uniform benefit package mean for patients and for health care providers? Second, should medical education be part of any standard benefit plan? Third, should a standard benefit plan be uniform? Should there be exemptions?

**Why a basic benefit plan?**

Will a uniform or standard benefit package make it easier for the consumer? The answer is maybe. Lest you think that I see my patients as no more than customers, I should define what I mean by a consumer. When I buy health insurance, I am a consumer. When I receive health care services, I am a patient. Those of us who provide health care services believe that our responsibility to the patient far exceeds the responsibility most businesses have to their customers. It is a different relationship.

In theory, a standard benefit package allows the consumer to make rational economic decisions. It allows the consumer to plainly see what services are covered and what are not covered. Health economists tell us that consumers are unable to compare the value of competing health insurance plans because there are hundreds of different plans on the market, each with a different set of benefits. How do we compare the value of a copayment on physician services in one plan to a limit on the number of mental health visits covered by a another plan.

Consumers must choose not only between different benefit packages but between types of plans. The consumer must choose between traditional indemnity plans, staff model Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Independent Practice Associations (IPAs), and an almost infinite number of variations of these models.

Each insurance plan also has its own schedule of out-of-pocket expenses. There are different levels of copayments and deductibles. Many employers require the employee to pay part of the cost of health insurance premiums. There are also the intangible elements, such as the number of forms the consumer turned patient must fill out or the type of service the patient receives when he or she calls the insurance plan. I call this the convenience factor.

This committee must address more than the standard benefit package. This committee must also look at whether there should be differences in copayment-deductible or employee contribution or in the types of forms patients must fill out and submit.

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scope of the problem based on the amount of mail each of your offices receives every day from Medicare beneficiaries and others in the community pleading for some help in understanding what their health insurance covers. A standard benefit package will eliminate much of this confusion.

A uniform benefit package has a very practical although mundane benefit for providers of health care services. The problems hospitals face billing health insurance plans is not very exciting and pales in comparison to the many important topics discussed before this committee; it is how we stay in business caring for patients. For providers of health care, the benefit package tells us which services are covered and how to bill the health insurance plan.

At a time when computers should handle most patients' bills, it often takes our patient accounting staff hours to manually match the payments from a patient's insurance plan to the patient's bill. There are over 10,000 health insurance plans in New York State. Ninety percent of our patients are covered by one of several health insurance plans - Medicare, Medicaid or Blue Cross, or one of the regional health maintenance organizations. It is relatively easy for hospitals to bill one of these major health insurance plans and, for the most part, the billing process is automated.

Billing for those covered by the thousands of other health insurance plans is an administrative quagmire. Matching a hospital's bill to a particular benefit package and the particular rules and idiosyncracies governing each of these plans is very time consuming. In general, my billing department spends three quarters of their time figuring out how to bill for services provided to a very small number of patients. The time and money we spend on reconciling patient bills is money and time we should be using for patient care.

A standard benefit plan would make our life and the life of the patient easier. A standard benefit plan will reduce administrative costs.

#### **Medical Education is a Basic Benefit**

Recently, there has been a great deal of discussion about graduate medical education and whether we train too many specialists and not enough primary care physicians. We do train too many specialists and not enough primary care physicians. While we may need to change how we train physicians as well as the types of physicians we train, we need to continue to educate and train new physicians.

Graduate medical education is of benefit to everyone in the country, not just to Medicare beneficiaries or to the citizens of those states or cities with large numbers of residency programs. By definition, every patient who sees a physician benefits from a physician training program. Quite simply, without those medical education programs, that physician would not be there.

Physicians trained in New York State, California, or Chicago open practices in Montana, Iowa, Mississippi, and even Cicely, Alaska. Supporting medical education is a national responsibility. Changing how physicians are trained does not diminish this responsibility.

As we rush headlong into a competitive environment or a managed competitive environment, it would be too easy to forget the value of medical education. Insurance companies, in their rush to be competitive in this new environment of insurance cooperatives and accountable health plans, will only view medical education as an expensive luxury. Under managed competition, health insurance plans would seek a competitive advantage by directing patients to non-teaching hospitals.



I would argue that medical education is a basic benefit and should be included as part of every health insurance plan in this country. Medical education and patient care are inextricably linked. Every time an insurance plan makes a payment to any hospital on behalf of a patient, the payment should include a small additional amount to cover our national responsibility to support medical education. This money should become part of a national fund allocated by a National Commission on Medical Education. The National Commission would not only have the power to allocate funds to graduate medical education programs but to use those funds as an initiative to support training the type of physicians we really need in this country.

I believe a similar model has been endorsed by the Physician Payment Review Commission (PPRC).

#### **A Standard Benefit Plan**

The debate over the basic benefit package will force every organized group in the country to trot out their tried, true but predictable arguments. Every provider group, from optometrists to chiropractors to faith healers, fearing that they will be left out of the standard benefit package, will come before this committee to make their case. Businesses will tell us that a comprehensive package of benefits will make this country uncompetitive in the world marketplace. And those of us with comprehensive health insurance plans want to keep our benefits while the rest of us with meager health insurance benefits want more. The debate is predictable and repetitive.

I do not mean to diminish the importance of the debate over the coverage of optometry services or the importance of staying competitive in the global economy. These are important questions. However, I would like to address several fundamental questions.

First, how uniform will the standard uniform benefit plan be? Will individuals or businesses on behalf of their employees be allowed to purchase supplemental insurance? Will it be supplemental insurance for services covered under the plan or for services not covered under the plan?

Those who advocate the sale of supplemental health care insurance argue that we already have a two-tier health care system. Those who can afford to pay more already get better health care. Unfortunately, this is true. Permitting the sale of supplemental insurance for services covered under the plan will quickly result in a further division in our health care system. Those without supplemental insurance will be relegated to public hospitals' waiting rooms and overcrowded clinics.

I strongly hope that this committee prohibits, by law, the sale of supplemental health insurance for services covered under the standard benefit plan.

I do not oppose the sale of supplemental insurance for services not covered under the standard plan. However, I do hope that the standard benefit encompasses all of the basic health services.

Second, will state Medicaid programs be subject to the provisions of the standard benefit plan? The Medicaid program is a hodgepodge of programs varying from state to state. Some states provide only the basic services required under Federal Medicaid Law while other states offer a host of optional services. I hope at a minimum state Medicaid programs are required to provide the benefits that are included in the standard benefit package. I would also recommend that states be permitted to offer, through their Medicaid program, services that are not included in the standard benefit package.

Third, should the standard benefit package apply to all insurance programs or should large companies like General Motors be permitted to create their own benefit package? Although it may be politically unpopular, I would recommend that the standard benefit package should apply to all health insurance plans, including self insured plans.

Fourth, the question of the day is what should the standard benefit package include? There is probably no right answer. This is my list.

1. Hospital Services
  - a. Inpatient Services
  - b. Outpatient Services
  - c. Emergency Services, including Ambulance Services
2. Physician Services, including Preventive Services
3. Clinic Services
4. Family Planning
5. Laboratory and X-Ray
6. Prescription Drugs (and in some instances, non-prescription drugs)
7. Hospice Care
8. Home Health Care
9. Long-Term Care Services
  - a. Phase-in of Nursing Home Services
  - b. Rehabilitation Services, including Extended Care Services
10. Drug and Alcohol Services
11. Some Mental Health Services
12. Pediatric Services
  - a. Pediatric Screening
  - b. Child Vision Services
  - c. Immunization and Well Baby Care
13. Dental Services
14. Case Management Services

There are many ways to enforce or mandate compliance with a standard benefit package. I believe that the federal government should encourage compliance through the tax code rather than prohibiting insurance companies from offering other products. I believe that in most instances the uniform benefit package will become the standard by which businesses measure their own health insurance plans.

The standard health insurance benefit package will be criticized by those that believe government has no role in the health insurance marketplace. I hope that this committee has the courage to enact national health insurance standards as part of national health care reform.

Thank you.

Mr. KLECZKA. Thank you very much.

Let's turn to our next witness from the American Academy of Physical Medicine and Rehabilitation, Dr. Leon Reinstein.

**STATEMENT OF LEON REINSTEIN, M.D., PRESIDENT, AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION**

Dr. REINSTEIN. Thank you, Mr. Chairman and members of the subcommittee.

I am Dr. Leon Reinstein, from the Sinai Rehabilitation Center in Baltimore, Md. I am here today as president of the American Academy of Physical Medicine and Rehabilitation.

What I would like to do is briefly tell you what physical medicine and rehabilitation is, what we view as the critical issue in health care reform today, and what we believe should be in the basic benefits package.

Our academy consists of 4,000 physicians who care for infants, children, adults and the elderly. These are patients who have physical disabilities such as cerebral palsy, juvenile rheumatoid arthritis, spinal cord injury like Mr. Palermo, traumatic brain injury, neck pain, back pain, work-related injury, amputations like Mr. Thomas and Mrs. Wildy, stroke and hip fractures.

These are disabilities which prevents someone from doing everyday things which we take for granted—dressing, bathing, eating, going to the bathroom, walking, driving a car, working, parenting a child, reading a book—those things that contribute to quality of life.

You have my written testimony which describes in detail what physical medicine and rehabilitation is, the benefits and effectiveness of physical medicine and rehabilitation, and the cost savings of physical medicine and rehabilitation. Previous speakers, Mr. Palermo, Mr. Thomas and Mrs. Wildy have eloquently described these effects and benefits to you today.

What I would like to briefly discuss is what the American Academy of Physical Medicine and Rehabilitation believes is the critical issue in the national health care reform debate, the underinsured.

A poor young adult who suffers a traumatic brain injury or a spinal cord injury and has no insurance will get Medicaid to pay for physical medicine and rehabilitation services. An injured worker will get work persons' compensation to pay for physical medicine and rehabilitation services. An elderly person who falls and suffers a hip fracture will get Medicare to pay for physical medicine and rehabilitation services.

But what happens to a 50-year-old worker who suffers a stroke, who has a steady income and has health insurance, but that health insurance does not cover physical medicine and rehabilitation?

The hardest part of my job as a physician is to explain to such a patient and their family that if they come to our inpatient rehabilitation unit, the hospital will have to bill them directly for physical medicine and rehabilitation services. They may pay over time, but they will be expected to pay the full bill. We cannot give them free care, if they have an income and if they have assets.

A typical stroke patient will stay 21 days at our inpatient rehabilitation unit at an approximate cost of \$15,000 to \$20,000. This



may represent half a year's gross earnings for a typical worker in the United States today.

This is this week's issue of Business Week, listing the income of the top 10 CEO executives in the United States. Number one in the United States is Mr. Thomas First of the Hospital Corporation of America, who earned \$127 million last year. A system of health care that permits 37 million uninsured Americans and 50 million underinsured Americans and results in the chair and CEO of a for-profit hospital chain earning \$127 million in a single year is a national disgrace.

In conclusion, the American Academy of Physical Medicine and Rehabilitation urges Congress to create a basic benefits plan that one, covers all 250 million Americans, two, prohibits preexisting conditions and exclusions, three, includes inpatient, home care and outpatient physical medicine and rehabilitation services, and four, protects against underservice and erosion of benefits in HMO's and managed care.

Health care, in general, and physical medicine rehabilitation, in particular, are the right of every American.

Thank you.

[The prepared statement follows:]



**TESTIMONY OF LEON REINSTEIN, M.D.**  
**American Academy of Physical Medicine and Rehabilitation**

Mr. Chairman -

I am Dr. Leon Reinstein and I am testifying on behalf of the American Academy of Physical Medicine and Rehabilitation, a medical specialty society representing about 4000 physicians specializing in Physical Medicine and Rehabilitation (PM&R). The Academy is also an active member of the Consortium for Citizens with Disabilities (CCD) and endorses the specific positions of the CCD on health care reform and on managed care. The Academy has, for many years, supported federal legislation to enhance access to health care for persons with disabilities. We are supportive of legislation in this Congress to provide comprehensive coverage for uninsured individuals, particularly individuals with physical disabilities. We are concerned, however, that legislation not establish systems for coverage which discriminate against persons with disabilities either through exclusions and experience rating systems or through the use of managed care programs which limit access to needed services for persons with disabilities and chronic conditions.

The Specialty of Physical Medicine and Rehabilitation (PM&R)

Physical Medicine and Rehabilitation (PM&R) physicians provide medical services and management in inpatient and outpatient settings to persons of all ages with physical disabilities which substantially limit function. We treat conditions such as stroke, spinal cord injury, arthritis, traumatic brain injury, and amputations. The field began in 1930 and grew after World War II with a focus on rehabilitation of the injured veterans.

The diversity of the profession is reflected in the wide variety of roles a PM&R physician has and the broad range of patients PM&R physicians treat. We deal with the prevention, diagnosis, and treatment of acute and chronic pain and musculoskeletal disorders such as arthritis, tendinitis, and low back pain, or sports or work-related injuries. PM&R also encompasses the treatment of patients with severe congenital or acquired pathology of the neuromusculoskeletal systems resulting in functional limitations. Examples of these disorders include spinal cord injuries, traumatic brain injuries, cerebral vascular accidents and multiple sclerosis.

Physical Medicine and Rehabilitation always has as its goal for the patient the attainment of maximum function not only physical function but also psychological, vocational, and social function. The PM&R physician is concerned with the whole person, his or her family, and environment. Ideally, our goal is return to productive employment for those of working age, independent living for those beyond working age or unable to work, and education and social integration for children with disabilities. Our practice involves us in many aspects of our patients' lives and quest for independence including collaborative work with vocational rehabilitation and special education programs.

Diagnostic tools in PM&R are those used by other physicians--medical histories and physical examinations, X-rays, and laboratory studies. However, we also use special techniques like electromyography, nerve conduction studies, and evoked potentials to determine the precise muscle or nerve problems resulting in functional loss. PM&R physicians are skilled in the administration of traditional drug therapies and modalities such as heat, cold, electrotherapies, biofeedback, traction, and therapeutic exercise.

The practice is now rather evenly split between practices which are hospital based and those which are office based outpatient practices. About 60% of our members are in group or solo private practice entities, but most of them provide services in inpatient and outpatient hospital settings as well as in their offices. The hospital based part of the practice takes place in 169 rehabilitation hospitals and 770 distinct rehabilitation units in general hospitals. About 60% of us practice in cities of over 200,000 and 80% practice in cities of 40,000 or more.

The PM&R physician serves as the attending physician for individuals with physical disabilities who are inpatients in a medical rehabilitation program. In this role, the PM&R physician is responsible for the diagnosis of need and management of the rehabilitation program and the routine medical needs of the patient. (1990 Medicare Guidelines for Physician Rehabilitation Services) Upon discharge from an inpatient medical rehabilitation program, the PM&R physician often serves as the primary care physician for the person with a spinal cord injury or traumatic brain injury. This role is undertaken in many cases because the patient desires continuity of general medical care. The Academy has adopted a position encouraging physicians in our field to be primary care physicians for persons with physical disabilities where this is appropriate for the patient. The lack of primary care services for persons with physical disabilities has become a well documented problem. (Burns, *Archives of Physical Medicine and Rehabilitation*, Volume 71, 1990)

Recent data from the Department of Health and Human Services estimates the requirements of PM&R to be about 6500 by 2000 and 9230 by 2020. (September 1992 the Department of Health and Human Services Report on Health Personnel in the United States) Currently, there are only about 4000 practitioners. Earlier Department of Health and Human Services' studies have indicated similar shortages.

Training in PM&R involves a residency program of four years which includes a first year of fundamental medical training followed by three years of specialty training in PM&R. In 1991, 97% of the 1158 residency positions offered were filled, one of the better rates in medicine.

### Whom Do We Serve

The 1991 Institute of Medicine report *Disability in America* stated that "Disability is a serious public health problem in America . . . with about 35 million persons experiencing some form of limitation in function and activity owing to chronic health problems or impairments. Approximately one-half of those persons had physical disabilities of the musculoskeletal or neuromuscular systems. (*Disability in America*, page 57.) The cost of disability has been estimated to be \$400 billion from disorders of the neuromuscular systems. The Institute of Medicine report indicates that disability expenditures for income support and medical care alone were about \$170 billion in 1986. Our role as PM&R physicians is to provide appropriate care and services to minimize these costs and expenditures, and we believe we are doing it well. The Institute of Medicine report puts it succinctly: Disability imposes an enormous cost on society. If we are successful in our role, and we think we are, we are assisting individuals with disabilities to function independently, to return to home and work where possible, and to reduce these costs at the same time.

Impairments considered the main sources of disability include the following conditions:

#### Adults

Stroke  
Traumatic brain injury  
Spinal cord injury  
Amputation  
Arthritis  
Chronic pain syndrome  
Rheumatic diseases  
Multiple sclerosis  
Burns  
Pulmonary diseases  
Cancer

#### Children

Cerebral palsy  
Scoliosis  
Motor disorders  
Muscular dystrophy  
Congenital oracquin  
Cranial disorder  
Spina bifida  
Congenital deformities

For many Americans with disabilities, secondary disabling conditions complicate recovery. Such conditions include muscle atrophy, obesity, ulcers, contracture, and depression. Rehabilitation measures are essential to restore normal activities and to prevent the onset of costly secondary disabling conditions.

#### Who has disabilities?

The likelihood of disability rises rapidly with age. According to the 1988 National Health Interview Study, the following percentage of various age groups have some degree of activity limitation:

Under 18	5.1%
18-44	8.4%
45-64	23.4%
65 and over	39.6%

The average newborn in America can expect to spend 12.8 years, out of 75 years of life, with some sort of activity limitation. Slightly less than half that time is, on average, the result of disabilities acquired before age 45. More disabling years are experienced by people later in life, principally due to chronic disease and arthritis. America's number one public health care problem will likely grow worse as the number and percentage of elderly Americans increase.

In the hospital inpatient setting, the patients we provide services to are individuals with stroke, spinal cord injury, head injury, amputations, arthritis, neuromuscular disease such as multiple sclerosis and muscular dystrophy and multiple trauma. Patients in inpatient hospital programs are transferred to rehabilitation much earlier than was the case a decade ago. They have significant medical complications, such as diabetes, heart conditions, and hypertension which they did not have 10 years ago, (Dobkin, Neuromedical Complications, Neurology and Rehabilitation, Volume 1, No. 1, 1987). The PM&R physician must manage the medical complications to enable the medical rehabilitation program to progress. Despite

the more complicated status of the patients, the lengths of stay have been lowered dramatically in the last decade. In the outpatient setting, the PM&R physician is most frequently dealing with the management of chronic pain, spine problems, industrial injuries, and joint and other musculoskeletal problems. His or her use of medication, exercise, and physical and occupational therapy is often an effective substitute for surgical intervention in back problems. A survey of chronic back pain patients recently identified the PM&R physician as the most effective of care providers for this prevalent condition.

### The Benefits and Effectiveness of PM&R

The evidence in the published literature of positive outcomes from PM&R services is now substantial. The positive benefits in terms of functional outcome were first demonstrated with regard to the rehabilitation of spinal cord injured individuals. Studies showed that organized systems of care in which medical rehabilitation was begun early resulted in earlier hospital discharges, less medical and disability cost, and greater independence. (Data from Model Spinal Cord Projects, Stover, 1981; Oakes, *Archives of Physical Medicine and Rehabilitation*, Volume 71, No. 9, 1990). Recently, these conclusions of positive benefit have been confirmed with regard to rehabilitation and long-term spinal cord injury (Klose et al., *Archives of Physical Medicine and Rehabilitation*, Volume 71, 1990). The remarkable stories of New York Jets lineman Dennis Byrd and baseball umpire Steve Palermo dramatize these data. Byrd was also the beneficiary of advanced technology in spinal cord injury trauma and surgical management. He was then attended by Kristjan Ragnarsson, a PM&R physician at Sinai Hospital in New York City in which he received comprehensive rehabilitation services.

Similar results with respect to early medical rehabilitation intervention and positive functional outcomes have been achieved regarding traumatic brain injury. (Spettell, *Archives of Physical Medicine and Rehabilitation*, Volume 72, 1991; Mackay, *Archives of Physical Medicine and Rehabilitation*, Volume 73, 1992). Early involvement in medical rehabilitation for a traumatic brain injury patient has been shown to reduce hospital stays by 1/3 the length of individuals not entering such programs. Cognitive function on discharge was greater by 40% and 94% returned home rather than to a nursing home compared to 57% who did not have trauma rehabilitation (MacKay, *Archives of Physical Medicine and Rehabilitation*, Volume 73, 1992). Inpatient rehabilitation of acute and chronic stroke patients has also demonstrated substantial functional gains after inpatient rehabilitation and those gains were maintained after discharge. (Davidoff, *Archives of Physical Medicine and Rehabilitation*, Volume 72, 1991) Outpatient care assisted in further improvement with respect to these gains. Gains in mobility and balance were substantially greater after rehabilitation than before.

The Institute of Medicine report *Pain and Disability*, 1987, indicates that "the general message from the literature on rehabilitation pain management programs is that they almost universally show good effects on the basis of a variety of outcome criteria (*Pain and Disability*, p. 242, 1987). The approach of such programs is often an interdisciplinary team approach utilizing physical modalities such as physical therapy and exercise. Behavioral methods may also be used and patient education in self care is also an important element.



Despite the evident benefits of physical medicine and rehabilitation services, the percentage of individuals needing but not receiving such services who are not receiving them is increasing. In a recently published study done at the University of Washington at Seattle, only 21% of persons with disabilities found to be needing physical medicine and rehabilitation services were actually receiving those services. (Evans, *Archives of Physical Medicine and Rehabilitation*, Volume 72, 1991) Only 10% to 21% of stroke patients ever receive medical rehabilitation services in inpatient settings. (Evans, *Archives of Physical Medicine and Rehabilitation*, Volume 72, 1991) Yet this same study indicates that the participants in organized, good oriented hospital inpatient medical rehabilitation programs had lower mortality, less time in nursing homes and were less frequently rehospitalized.

#### Savings From Physical Medicine and Rehabilitation

Decreased in Long-Term Disability Costs. Medical rehabilitation substantially reduces outlays by private providers and by public programs. Estimates of overall savings to benefit programs range from \$1 billion to \$2 billion annually.

Northwestern National Life Insurance Company surveyed 2,212 long-term disability cases from June 1981 through March 1988 in order to determine the effectiveness of the company's individualized case management system. From the insurer's perspective, success is achieved when the claimant returns to work; the claimant recovers medically to the point of full employability; or benefits terminate because the claimant begins to receive Social Security Disability Income (SSDI) or is otherwise no longer eligible for benefits.

The survey included light and heavy industry, and was broken down into back, musculoskeletal, cardiovascular and mental disabilities. In 1987, every dollar spent on outside rehabilitation generated \$30 in Long-Term Disability reserve savings. (Long-Term Disability reserve is the amount of money set aside, on the basis of an actuarial formula, to pay future benefits.) Estimated reserve savings were \$100 million from 1981 through 1988.

It should be pointed out that a portion of the reserve savings occurred when claimants became eligible for SSDI. Nevertheless, for all categories of disability except one (cardiovascular, heavy industry) the greatest savings occurred due to successful rehabilitation.

Northwestern's aggressive approach may have been more effective than the industry norm in the mid-1980s. In 1986, a survey conducted by the Health Insurance Association of America found only 70 out of 139 insurers had rehabilitation programs in place. The majority of these programs were informal, rather than reflecting policy provisions. Of the 55 companies which tracked cost and savings information, over 88% reported measurable savings. In 1985, data showed an average cost benefit of \$11 per dollar invested.

Decreased Medical Care Costs Studies of various disability groups indicate substantial reductions in hospital stays and readmissions, particularly if rehabilitation is begun early in the patient's acute care. This is easily demonstrated with traumatic injuries, where insurance liability is large and where companies have come to know that rehabilitation provides substantial savings over a lifetime. For example, length of hospitalization is reduced one half to one third for traumatic brain injury patients.

**Back injuries**, a frequent basis for workers' compensation claims, also show considerable reductions. Doctor's visits are five times less, and repeated surgery less than half as likely, for individuals plagued by low back pain who undergo rehabilitation.

Stroke treatment reduces the need for long-term hospitalization, or readmission to hospitals, with rehabilitated patients less than half as likely to be rehospitalized a year after their initial attack.

**Decreased Nursing Home Costs** Many studies report that rehabilitation increases the likelihood of discharge to the patient's home, as opposed to a nursing home or other expensive facility. Excluding traumatic injuries, which would show even greater savings, between 50,000 and 100,000 people a year are returned home instead of going into nursing homes, at considerable expense to government, families and insurers. Savings estimates range from \$500 million to \$1 billion annually.

**Chronic Pain** Pain is the third leading cause of disability in America, affecting approximately 80 million workers in the course of a year. The total cost of lost working days, medical fees, and workers' compensation is between \$85 billion and \$90 billion per year, with an estimated 700 million working days lost. The most frequent causes involve lower back pain and headache, while other sources include arthritis, cervical pain, facial pain, and myofascial syndrome.

A relatively small proportion of patients who suffer from chronic pain syndrome account for a disproportionate share of overall costs. Such patients may suffer a total disruption of their lives, resulting in high treatment costs, workers' compensation costs and economic loss. Such patients are the primary beneficiaries of multidisciplinary pain clinics.

A 1992 review of 65 previous studies considered the effectiveness of such multidisciplinary centers, as compared to conventional physical therapy or standard medical treatment. Conventional physical therapy was better than no treatment or conventional medical treatment, but considerably less effective than a combination of physical therapy, medical treatment and psychological counseling. Center patients were almost twice as likely to return to work (68% versus 36%).

Such results demonstrate considerable savings to workers' compensation insurance carriers, with one report showing an average potential lifetime cost savings of \$238,515 per patient.

Similar savings have been demonstrated for people plagued with low back pain resulting from industrial injuries. Patients who entered a functional restoration treatment program for chronic low back pain were compared with patients not treated. After one year, 85% of those in the treatment group were either working or in a training program as contrasted with 39% in the comparison group. After two years, the contrast was 87% versus 41%. Equally significant was the reduction in required additional surgery (9% for the treatment group versus 20% for the comparison group) and a roughly five times higher rate of patient visits to health professionals for the comparison group. Lastly, reinjury rates for the treatment group were no higher than for the general population, while the comparison group had a higher incidence of reinjury. Taking into account treatment costs, wage loss

and workers' compensation payments, a conservative estimate of savings per 100 treated patients is \$1,383,100 at the end of two years.

#### Scope of Necessary Benefits For Persons With Disabilities

It is well documented that an estimated 35 million people lack health insurance altogether and close to 50 million lack insurance for at least part of the year. Sadly, the age group most affected are children or young adults 19 to 24. The lower the income, the less one is likely to be insured. Many persons with disabilities and chronic illness are either uninsured or underinsured because of their condition. (See *Journal of American Medical Association*, May 15, 1991.) In addition, existing insurance coverage is often very limited with respect to medical rehabilitation care and nonexistent with respect to long-term care. Physical medicine services related to the management of musculoskeletal conditions, acute and chronic pain and occupational impairments are cost-effective, nonsurgical methods of returning persons with such disabilities to work or other productive activity. Health insurance often does not cover such services or outpatient rehabilitation services, durable medical equipment and home health care. Some policies are unclear even as to inpatient hospital coverage for rehabilitation.

The American Academy of Physical Medicine and Rehabilitation believes that:

- There should be an end to discrimination against persons with disabilities or chronic illness in all health insurance offered in the United States. Specifically, legislation should prohibit pre-existing condition exclusions and premium rating systems and underwriting systems which result in excessive cost for coverage for such persons.
- Basic health insurance should be comprehensive and extended to all Americans on an equal basis regardless of income.
- Coverage should include (a) inpatient medical rehabilitation services that are properly organized, goal directed and furnished in residential settings; (b) properly organized, goal directed outpatient medical rehabilitation services in all appropriate settings; (c) professional services of physicians including physical medicine services for treatment of musculoskeletal, neuromuscular or other conditions; and nonphysician services as authorized by Medicare law including services of psychologists; (d) prosthetic and orthotic devices and durable medical equipment; (e) patient education in self-care and preventive measures for persons with disabilities and chronic illness. Rehabilitation coverage should be related to the goals of improvement in function over time or the prevention of deterioration in function or loss of function over time.
- Catastrophic Protection. There should be limits on annual and lifetime out-of-pocket expenses for deductibles and coinsurance. This is most important for patients with chronic illnesses or disabilities, such as cancer, spinal cord injury or traumatic brain injury with the complications that follow as well as very high "front end" costs.
- Prescription drugs and long-term care, including home care, should be covered in a catastrophic program.

- In any system with emphasis on delivery through HMOs or "managed care," there must be protections against underservice and erosion of benefits of those with severe chronic and disabling conditions and special needs (such as the need for medical rehabilitation of the spine injured, head injured person, or the multiple sclerosis or osteoporosis patient). This protection could be provided by empowering beneficiaries to choose their provider and service outside the "plan"; by providing for joint case manager-beneficiary decisions on services; by allowing the providers to appeal on behalf of the beneficiary to a review board of specialists, primary care physicians, and consumers; and by enabling the beneficiary with special needs to select by right a PM&R physician as a primary care provider.

I would like to emphasize the need to cover the services of PM&R physicians at least in PM&R as primary care physicians for their patients if the patient desires such an arrangement. Often such PM&R physicians must furnish primary care services to spinal cord injury, traumatic brain injury or stroke patients. No one else will and many of us are capable to perform that role. The lack of primary care services for the severely physically disabled patient often leads to costly rehospitalization due to preventable complications such as infections and skin problems.

We believe also that any changes in the financing of graduate medical education should not discourage by reduced payments the training of PM&R physicians. Our field has been in short supply for many years and while we are making progress in expanding the numbers of practitioners in the field, we still are a shortage field. Also, many of us provide primary medical care to our patients on an ongoing basis. We, therefore, do not believe that we should have our residency training support reduced; if anything, it should increased as is the proposal for internal medicine, family medicine, and pediatrics.

I would also like to emphasize the importance of long-term care services intended to enable persons with disabilities to live independently in their homes or assisted living arrangements. Such services include home care, homemaker, personal assistance services, and respite care. A recent study by Nossek has found that the use of personal assistance services by stroke, spinal cord injury, and traumatic brain injury patients to assist in activities of daily living such as dressing, feeding and bathing enabled such individuals to maintain their health. Problems which were prevented included skin problems such as decubitus ulcers, urinary tract infections, pulmonary infections and contractures. Reliance on family assistance alone was inadequate. The result of inadequate assistance has been hospital readmissions for infections, and skin breakdown. (Nossek, *Archives of Physical Medicine and Rehabilitation*, Volume 74, No. 2, 1992)

### Limitations on Benefits

We have recently been experiencing capricious limitations by some managed care systems on benefits of entire classes of patients without regard to their individual needs. All stroke patients have been determined to be unable to benefit from comprehensive services in rehabilitation hospitals or rehabilitation units of acute hospitals. All have been channelled to nursing facilities where there is not skilled rehabilitation nursing nor the necessary intensity of physical and occupational therapy services. Physician visits to patients are very limited and PM&R physicians cannot be used. While skilled nursing facility



services may be appropriate for some of these patients, some will not benefit and will deteriorate in functional terms. We object to these programs strenuously.

We would support the use of professionally developed criteria for the rehabilitative care of persons with physical disabilities. In the past five years, we worked with the Health Care Financing Administration on national guidelines for physician services to patients in rehabilitation hospitals or units. This effort was necessary to overcome capricious limits by a few carriers. In the end the standards helped the carriers and the field. The use of such professionally developed guidelines and the ability of patients to have a role in choosing their own care and treatment plan should drive the system not the "rules of thumb" of bureaucrats managing systems but not understanding the individual needs of chronically or disabled persons.

We are very supportive of "outcomes" research to improve the effectiveness of all medical care including medical rehabilitation. Such research and its use in the development of practice guidelines by professionals can assist in restraining unnecessary costs. In this respect, we were very active in advocating for the creation of a research agency at NIH to focus on improving the effectiveness of PM&R services. That agency was created in 1990.

#### Conclusion On Benefit Package

We are encouraged by the emphasis being placed by the Administration on access to care and, it appears, on comprehensive benefits. We believe the Medicare benefit package is generally a good one for persons with disabilities for it has always covered hospital based rehabilitation care, physical medicine and rehabilitation physician services, and DME for example. It includes most of the services such persons need except patient education services, long-term care, and prescription drugs. We would also support a catastrophic illness program to protect beneficiaries from the costs of very expensive care. However, we would strongly object to a program which promised these benefits but then rendered them inaccessible through a managed care or HMO system which did not allow access to rehabilitation hospital services, and did not allow the patient with a disability or chronic illness to be managed by the rehabilitation program whom they chose to manage their chronic condition and general medical care.

Mr. KLECZKA. Doctor, thank you very much for your very pointed and strong statement.

We now would ask Marilyn Moffat, president of the American Physical Therapy Association, for her testimony.

**STATEMENT OF MARILYN MOFFAT, PH.D., PRESIDENT, AMERICAN PHYSICAL THERAPY ASSOCIATION, AND PROFESSOR, NEW YORK UNIVERSITY**

Ms. MOFFAT. Mr. Chairman and members of the subcommittee, my name is Dr. Marilyn Moffat, and I am currently president of the American Physical Therapy Association, as well as a practicing physical therapist and professor of physical therapy at New York University.

The association represents over 56,000 physical therapists, physical therapist assistants and students of physical therapy in the United States. We certainly share the concerns of the American public, our political leaders and other health care providers regarding the need to make quality health care services available and affordable to all Americans. We were one of the first health provider groups to endorse the President's outline for reform when we released our position paper late last year.

A key element to the success of health care reform is a comprehensive benefits package which provides consumers with incentives to prevent injury and illness and which provides security, should these events occur. To achieve this objective, any basic benefits package should cover the diagnostic, treatment and preventive services provided by physical therapists in both inpatient and outpatient settings.

Arbitrary caps and limits on care should be avoided. Once an individual who suffers from a stroke, head injury or other extensive disabilities reaches the artificial cap, that person is sent back to the ranks of the uninsured, since they do not have the insurance to meet their increasing medical needs. Rather, care should be based on necessity, with review for the effectiveness of therapy.

The association recognizes that there is a point at which certain treatments lose their cost-effectiveness. We also recognize that, as health professionals, we must practice judiciously. The association is willing to work with policymakers and insurance to define the limits of skilled physical therapy care through the further development and refinement of practice guidelines in our professional arena. Thus, we can more clearly define necessity with solid standards of practice.

The standard package should provide for assistive technology and devices to allow individuals that we serve to live functional, independent lives. Examples of equipment needed include canes and walkers, wheelchairs, prosthetic and orthotic devices, many of which you have heard about already.

In addition, it should cover prevention and wellness programs provided by physical therapists, which should include, but certainly not be limited to, some of the following examples: prenatal instruction for posture alignment and strengthening to prevent those low back pain problems and the varicosities that occur with pregnancy; weight-bearing and safe conditioning exercise programs for the prevention of osteoporosis, an increasing problem with our aging popu-

lation; industrial disability programs to prevent job-related disabilities, including low back pain; cardiac and pulmonary disease wellness and rehab programs; high-risk infant and young child screenings and scoliosis screenings.

We certainly have been a key in many facets of health care delivery in the past years since the inception of the Medicare program, and certainly long before then. We provide services in inpatient and outpatient settings, and we have been covered under the health care plans, including Medicare and Medicaid, the HMO Act of 1973, workers comp and CalPERS.

There are numerous studies which are attached to our informed testimony which will indicate the benefits of physical therapy services, and these include many, many outcome studies which show the hundreds of thousands of dollars that have been saved through intervention.

In addition to covering diagnostic and treatment services of physical therapists, the assistive technology and devices our patients require to live functional, independent lives must also be covered.

A final factor that we would hope would be employed in any type of reform package that occurs would include the fact that physical therapy services be rendered by physical therapists who are licensed in the 50 States of this country and reimbursement for physical therapy services be given only to those licensed individuals and not to others.

I commend you for holding this hearing and look forward to work with the subcommittee on reforming our health care system.

Thank you.

[The prepared statement follows:]



## TESTIMONY OF MARILYN MOFFAT American Physical Therapy Association

Chairman Stark, Congressman Thomas, members of the Ways and Means Health Subcommittee, my name is Marilyn Moffat. I am President of the American Physical Therapy Association, a practicing physical therapist and a professor of physical therapy. The American Physical Therapy Association represents over 56,000 physical therapists, physical therapist assistants and students of physical therapy.

The American Physical Therapy Association shares the concerns of the American public, political leaders, and other health care providers regarding the need to make quality health care services available and affordable for all Americans. Physical therapists are concerned not only as members of society, but also as health care deliverers in a profession whose focus is rehabilitation and maximizing function. The American Physical Therapy Association was one of the first health provider groups to endorse the President's outline for reform when we released our position paper late last year.

A key element to the success of health care reform is a comprehensive benefits package which provides consumers with incentives to prevent injury and illness and which provides security should these events occur.

### MAKEUP OF PHYSICAL THERAPY BENEFITS IN THE CORE BENEFITS PACKAGE

We understand from discussions with White House personnel and press reports that the President's benefit package will cover rehabilitation services including physical therapy. We are pleased that Americans will continue to have access to this essential component of health care.

When fully developed, the basic benefits package should cover:

- The diagnosis, treatment, and preventive services provided by physical therapists in both inpatient settings (hospitals, skilled nursing facilities, and through home health agencies) and outpatient settings (physical therapists' offices, patients' homes, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, hospital outpatient departments, and nursing homes).

Arbitrary caps and limits on care should be avoided in the development of a package. Such limits on physical therapy services harm members of society who greatly need our care. Once an individual who suffers from a stroke, head injury or other extensive disability reaches an artificial cap, that person is sent back into the ranks of the uninsured because they do not carry insurance to meet their medical needs. Rather, care should be based on medical necessity with review for the effectiveness of therapy, as is currently done in most settings under the Medicare program.

The American Physical Therapy Association recognizes that there is a point at which certain treatments lose their cost effectiveness. We also recognize that as health care professionals we must practice judiciously. The Association is willing to work with policymakers and insurers to define the limits of skilled physical therapy care through the further development and refinement of practice guidelines in the physical therapy field. Thus we can more clearly define "medical necessity" with solid standards of practice.

- Assistive technology and devices to allow individuals to live functional, independent lives. Examples of equipment include canes, walkers, wheelchairs, and prosthetic and orthotic devices.
- Prevention and wellness programs provided by physical therapists: including but not limited to:
  - 1) prenatal instruction for posture alignment and strengthening;
  - 2) weightbearing and safe conditioning exercise programs for the prevention of osteoporosis;
  - 3) industrial disability programs to prevent job related disabilities including repetitive motion injuries for assembly line workers;
  - 4) cardiac and pulmonary disease wellness and rehabilitation programs;
  - 5) high-risk infant and young child screenings; and
  - 6) school based scoliosis screenings. Physical therapists teach prevention and wellness in many settings including private offices, the worksite, retirement centers, schools, and group homes.

We are pleased to see that when considering "prevention" services, policymakers are beginning to look beyond the traditional services of vaccinations, prenatal care and the like, to disability prevention programs. According to the National Institute on Disability and Rehabilitation Research, Digest of Data on Persons with Disabilities: 1992, an estimated 40 million Americans live with some form of disability. Total direct costs, including health care expenditures, loss of productivity in the work force,



and loss of wage-earning ability among other household members, are estimated at 6.5% of the GNP.

According to the U.S. Administration on Aging, there currently are nearly six million noninstitutionalized people over 65 who have physical impairments. With the aging of the population, the proportion of people at risk for disability will continue to climb.

The number of individuals with disabilities and the economic impact of their health problems will increase if appropriate prevention and rehabilitation programs are not introduced. Many primary and secondary disabilities are preventable and physical therapy already plays a critical role in reducing disability through prevention programs. For example, an estimated 5.2 million Americans are disabled by low back pain; half of these individuals are chronically disabled. Low back pain is the most common cause of disability among the population under age 45 years and the third most important cause in the population over 45 years of age. The majority of back injuries are job related among the working population. In 1986, the annual cost of compensable back pain was estimated at \$11.6 billion. Physical therapy is widely viewed as the most cost effective and best type of care for preventing and alleviating the effects of low back pain.

The cost effectiveness of physical therapy programs which prevent disability in the work site is well documented. According to the Washington Business Group on Health, physical therapist intervention resulted in the following savings for some major corporate employers:

Coors . . . . .	\$604,000 total net savings;
Potomac Electric . .	\$500,000 yearly;
Lockheed . . . . .	\$105,000 yearly;
Westmoreland Coal	\$ 53,130 yearly; and
Mississippi Power . .	\$ 45,000 yearly.

Physical therapy services are among the most cost effective health services because a limited course of physical therapy often shortens a hospital stay, prevents future injury, and improves health outcomes. A few examples drawn from current scientific literature support this assertion:

- Mackenzie and others note that the use of chest physical therapy techniques reversed/prevented alveolar collapse and pneumonia for designated post-operative patients at risk for such.

Mackenzie CF, Shin B, McAsken TC. Chest Physiotherapy: The Effect on Arterial Oxygenation. *Anesth Analg* 57: 28-30, 1978

- In a randomized controlled trial of physical therapy provided for post-operative pulmonary complications, Morran and others state: "Routine prophylactic postoperative chest physical therapy decreased significantly the frequency of chest infection."

Morran CG, Finlay IG, Mathieson M, McKay AJ, Wilson N, McArdle CS: Randomized Controlled Trial of Physiotherapy for Post-operative Pulmonary Complications. *BR J Anaesth* 55: 1113-1117, 1983.

- Hayes has identified that the early use of physical therapy with stroke patients (within 72 hours of insult) increased overall function including mobility and decreased the need for future hospitalization.

Hayes SH, Carroll SR. Early Intervention Care in the Acute Stroke Patient. *Arch Phys Med Rehab*, 67: 319-321, 1986.

- Rutherford, while noting that "osteoporosis is currently the major cause of bone fractures in post menopausal women and older people and is associated with a high personal and medical cost," found that exercise conditioning, a physical therapy procedure, prevents or reverses the effects of this debilitating condition and thus contributes significantly to the reduction of falls in this particular population.

Rutherford OM. The Role of Exercise in Prevention of Osteoporosis. *Physiotherapy*, 76: 522-525, 1990.

- Ryden and others report on a hospital-based physical therapy back care program that resulted in a one-year \$200,000 decrease in back care costs and a reduction of incidents per thousand employees from 31 to 15.

Ryden L, Alicia, PT, MPH, et al. Benefits of a Back and Light Duty Health Promotion Program In a Hospital Setting. *Journal of Community Health*, Vol 13, No. 4, Winter, 1988.

- A retrospective audit of patients post-myocardial infarction in Great Britain showed that patients who underwent cardiac rehabilitation, including physical therapy procedures such as exercise conditioning and education, spent less than half the amount of time in a hospital as a result of readmissions than did patients who received only routine care.

Kehl P. A Retrospective Look at the Effects of Cardiac Rehabilitation - Post Myocardial Infarction. *Physiotherapy* 77, 77-80, 1991.

As a supplement to these examples, the Attachment to this testimony includes a bibliography of articles that address the effectiveness of physical therapy intervention across a spectrum of conditions and as a means of preventing initial trauma, or deterioration or reoccurrence following an initial trauma.

The American Physical Therapy Association believes that based on the experiences of major employers and insurers, it is possible to define affordable limits on a package of preventive physical therapy services that will save many times the cost of such services.

### CURRENT DELIVERY OF PHYSICAL THERAPY SERVICES

Services of physical therapists should be a key component of any health care reform package for the following reasons:

#### 1) PHYSICAL THERAPISTS ARE A KEY COMPONENT OF THE HEALTH CARE DELIVERY SYSTEM PROVIDING SERVICES TO A WIDE RANGE OF PATIENTS IN A MULTITUDE OF SETTINGS

Physical therapists' education and clinical experience uniquely prepare them to manage care related to functional improvement, to relieve pain, and to prevent the onset of disease and functional disability. Through evaluation, diagnosis and individualized treatment programs, physical therapists both treat existing problems and provide preventive health care for people with a variety of needs.

Physical therapist care, provided at the acute, rehabilitative, or preventive stages, strives to achieve increased functional independence and decreased functional impairment. Through timely and appropriate intervention, the physical therapist frequently reduces the need for costlier forms of care such as surgery, as well as shortens the length of institutional stays. Physical therapist preventive care forestalls or prevents the development of functional deterioration and the need for more intense care through hospitalization or extended care facilities.

Physical therapists are health care professionals who are:

- graduates of professional programs of physical therapy accredited by the APTA's Commission on Accreditation in Physical Therapy Education, which is recognized by the Council on Post-Secondary Accreditation and the U.S. Department of Education; and
- licensed in all states and territories of the United States.

Physical therapists practice in a wide range of inpatient and outpatient settings including:

- |  |                                   |
|--|-----------------------------------|
| • hospitals                                    | • extended care facilities        |
| • nursing facilities                           | • industry                        |
| • home environments                            | • sheltered workshops/group homes |
| • schools                                      | • community education programs    |
| • day care centers                             | • sports settings                 |
| • rehabilitation facilities                    | • schools                         |
| • physical therapy clinics and private offices |                                   |

The role of the physical therapist varies with the particular setting. However, services which are common to all settings include:

- determining the need for services across a broad spectrum of patient conditions, involving the musculoskeletal, neurologic, cardiac and pulmonary systems at

stages extending from immediate intervention in the acute setting (e.g. acute respiratory failure) throughout various levels of acute hospital care (e.g. in early mobilization of a patient with total hip or knee replacement) and through the habilitation and rehabilitation process in both inpatient outpatient and community settings;

- evaluating the patient's functional status;
- developing and implementing a plan of treatment with the patient and family, and determining the involvement of appropriate health care personnel in addressing the patient's functional impairments;
- administering, modifying, and coordinating therapeutic services that focus on posture, locomotion, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain and functional abilities in daily living;
- participating in peer and utilization review activities; and
- providing consultative, educational, and other advisory services to patients, families, other health care personnel, and the community. These services include wellness and other prevention programs.

## 2) PHYSICAL THERAPY SERVICES ARE COMPREHENSIVELY COVERED IN PUBLIC AND PRIVATE PROGRAMS

Both inpatient and outpatient physical therapy is commonly covered in Federal and State as well as private insurance plans. The following is a summary of physical therapy coverage in health care plans:

**MEDICARE** -- The federal Medicare program covers physical therapy services in a full range of inpatient and outpatient settings. Generally, Medicare will cover physical therapy services if:

- the services are reasonable and necessary;
- the services are such that they must be performed by or under the supervision of a qualified physical therapist;
- there is an expectation that the condition will improve significantly in a reasonable period of time; and
- the amount, frequency, and duration of the services are reasonable.

**MEDICAID** -- Physical therapy services are broadly covered within the Medicaid program. Every state is mandated to cover physical therapy when provided in an inpatient setting and under the Early and Periodic Screening, Detection and Treatment (EPSDT) program. While outpatient physical therapy is an optional benefit, 44 states have chosen to cover this service.

**WORKERS' COMPENSATION** -- All State workers' compensation programs cover physical therapy services provided in both inpatient and outpatient settings.

**HEALTH MAINTENANCE ORGANIZATION ACT OF 1973** -- Short term rehabilitation services and physical therapy is included in the basic benefits package if there exists the expectation that significant improvement of a member's condition will occur within a period of two months.

**CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM (CalPERS)** -- The plan covers physical therapy services provided for a period not exceeding 60 calendar days per condition following the date of the first physical therapy session. However, physical therapy can be extended upon the plan's approval if medically necessary and the condition will improve significantly.

**PRIVATE INSURANCE** -- The private health insurance industry also routinely covers physical therapy services. While insurers may limit the number of visits covered or apply an annual monetary cap, very few plans limit coverage by specific diagnosis or clinical indication.

Major treatment areas for which coverage is available include head injuries, strokes, heart attacks, spinal cord injuries, orthopaedic problems, burns, amputations, Parkinson's disease and arthritis. It is estimated that about 78,000 physical therapists assist 900,000 individuals daily to restore health and alleviate pain.

### SUMMARY

Physical therapists are an integral part of the health care delivery system. We provide services to a wide spectrum of patients in a wide range of settings: from newborns to older Americans, and from community centers to large teaching hospitals. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all federal, state and private insurance plans.

In addition to covering diagnostic and treatment services of a physical therapist and the assistive technology and devices our patients require to live functional, independent lives, we believe that the preventive services of physical therapists should also be included in a basic benefits package. Together, these benefits will greatly assist in the creation of a healthier and more secure society.

We commend you for holding this hearing and look forward to working with the Subcommittee on reforming our health care system.



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Mr. KLECZKA. Thank you very much, Dr. Moffat.

Dr. George Zitnay, president of the National Head Injury Foundation will be next, please.

**STATEMENT OF GEORGE A. ZITNAY, PH.D., PRESIDENT,  
NATIONAL HEAD INJURY FOUNDATION**

Mr. ZITNAY. Thank you very much, Mr. Chairman and members of the committee.

My name is George Zitnay. I am president of the Head Injury Foundation. I am happy to be here today. It is interesting to listen to previous speakers. I am not coming here to ask you to support any particular therapy. I am here today representing the 2 million Americans who every year sustain a head injury. I am here to talk about the consumers and the way the consumers feel they need to be represented in this discussion on health care reform.

As you know, head injury in this country is the leading cause of death and disability among young people. Unfortunately, every 15 seconds someone sustains a head injury in this country. Unfortunately, most of us don't really think about head injury when we talk about health care reform. What we often talk about is physical restoration, not cognitive rehabilitation. But just think for a moment what would happen if, in fact, you could not remember where you were when you wake up in the morning; if you could not remember, do you put your sock on first or your shoe on first; if you could not remember if you were married or not married.

My point is that people with cognitive disability have the right to have access to health care, have a right to be heard. Every year in this country, over 100,000 people die as a result of head injury. With the increasing violence that we see every day in our streets in America, unfortunately, organizations like mine, the National Head Injury Foundation, receive more and more calls and cries for help.

If, in fact, we are going to reform the health care program in this country, and we laud your efforts in doing such, we would like to make sure that people with traumatic brain injury are included and that their needs are met.

Just one example: Little Mason, who was 5 weeks' old when he sustained his severe head injury, was with his mother snugly being carried by her. She was crossing the street. A car ran a red light, smashed into mom and propelled little Mason into an oncoming car. Mom sustained a minor head injury, but little Mason had a profound brain injury. He is now 15 months old. When this happened, his father, his mother was in a coma, was left with the devastating experience. He was told not to hope for much, because he was going to die.

He is 15 months old today, and because of rehabilitation, because of physical therapy, occupational therapy and because of our humane policy of scoop and run, picking people up and getting them to the best medical care, he is alive. But what will his quality of life be like for the next 50 or 60 years? Think about it. He is totally dependent.

What we ask you to consider for the Masons of the world and for all the others—any one of us can sustain a brain injury at any time—is that, in fact, you remember that long-term care has to be



included, that you remember that the physical therapies, the occupational therapies, the neuropsychiatric care that a person would need are included in any reformed health care system. For people with cognitive disabilities, these therapies are just as important as any other health care.

We also believe that community-based services are the best services. People with head injuries are best cared for at home, with the people who love you and know you, and we urge you to consider that service, which is a lot less expensive than care in other types of facilities, be considered in your package. We urge you that these continuum of services be included in the package adopted by Congress.

We think it is important to avoid the bias in our current system towards acute and hospital nursing home care. The goals of any health care program should be to restore the person to the most effective functioning possible. All of us want that. We urge you to consider that. We also urge you to support and include community-based programs in the package. They are not only more cost-effective, but more humane.

While some individuals with TBI, traumatic brain injury, will need long-term care, many can function in community settings. In other words, the care should be appropriate to the needs of the individuals. If, in fact, that is taken into consideration, we believe that the tremendous cost to our society today of caring for people with traumatic brain injury can be significantly reduced.

We also urge you, as others have, to be aware of the issue of the preexisting condition. Mason will never get health care insurance under the existing program. His mom and dad are a young couple. This is their first child. My point is that we need that type of consideration to eliminate the preexisting condition barrier.

We would also like you to consider that specialized programs in medicine need also to be considered, so that people have choices, because a Mason of the world needs physical medicine and that type of specialized care, provided by a specialist.

Finally, I want to say to you that prescription drugs and all the other types of services that any person with a health care need has, people with traumatic brain injury need.

Thank you very much for your consideration. I would like to have my written testimony submitted into the record.

[The prepared statement follows:]



**TESTIMONY OF GEORGE A. ZITNAY**  
**National Head Injury Foundation**

Distinguished Chairman and members of the Subcommittee, my name is George Zitnay, Ph.D., and I am the President of the National Head Injury Foundation. I appreciate the opportunity to appear before you today and ask that my full written statement be placed in the record.

The National Head Injury Foundation (NHIF) is a membership organization whose mission is to improve the quality of life for persons with traumatic brain injury (TBI) and their families and to promote the prevention of TBI.

**WHAT IS TRAUMATIC BRAIN INJURY?**

Every year in the United States, two million people sustain a traumatic brain injury, one every fifteen seconds. Of these two million, 100,000 will die; 70,000 to 90,000 will suffer irreversible debilitating loss of function; 5,000 will develop epilepsy as a result of the injury and 2,000 will exist in a coma. The direct and indirect costs associated with TBI are enormous: approximately 25 billion dollars per year including medical and rehabilitative treatment, and support services and lost income.

TBI is the leading cause of death and disability among individuals 15 to 24 but the elderly and the very young are also at high risk. Motor vehicle crashes, falls, and violence are the leading causes of TBI.

The effects of TBI are physical in the sense of loss of physical function; cognitive, including losses such as deficits in attention, memory and general intellectual performance; and may also involve linguistic and perceptual function losses, and behavioral effects including emotional and personality changes.

Early intervention, inpatient medical rehabilitation and out-patient follow up are all critical to good outcomes. Individuals sustaining traumatic brain injury also require coordinated and specialized services including post-injury supervised programs facilitating reentry into the community. Many individuals with TBI have difficulty reentering society and require community-based rehabilitation, follow-up and integrated community services.

Studies show that individuals who receive care in formalized TBI early intervention programs have significantly better outcomes than those in non-formalized programs. For example, in one study, length of stay was reduced by one third, and cognitive levels at discharge were significantly higher. In addition, a much higher percentage of individuals were discharged to home as opposed to institutional care.<sup>1</sup>

In structuring a basic medical benefits package, we must be careful not to turn back the clock on the progress currently being made by limiting coverage for these state of the art programs.

**BASIC MEDICAL BENEFITS: MEETING THE NEEDS OF INDIVIDUALS  
WITH TRAUMATIC BRAIN INJURY**

A basic medical benefits package under a reformed health care system should have as one of its principle goals, assuring that individuals with traumatic brain injury receive appropriate and timely care. This should include the entire continuum of care from emergency medical service at the site of the injury, intensive inpatient rehabilitation in the hospital, and long-term support in the most appropriate setting, often the community and home. The goal should be to return individuals with TBI to the community and productive employment or school wherever possible. Where this is not possible, the goals should be to restore as much function as possible, consistent with quality of life goals.

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<sup>1</sup> Archives of Physical Medicine and Rehabilitation, vol 73, July 1992, p. 635.)

### Community-Based Services:

Because many individuals with TBI have difficulty transferring skills learned in hospital-based facilities, community-based programs such as transitional living centers, day treatment programs and out-patient therapy services are often critical and should be part of any basic medical benefit package. Such programs are functionally oriented with the focus on helping the individual with TBI to live independently in the community. The NHIF has as one of its missions assisting in the creation of such programs.

We urge that these continuous services be included in any health benefits package adopted by Congress. We think it is important to avoid the bias in our current system towards acute and hospital or nursing home programs. The goal of services should be to provide the most effective therapy possible in the most cost effective setting. Community-based programs are frequently not only more effective but also save money because the site of service need not be an expensive facility. However, facility-based care, when appropriate, is critical to the needs of people who have severe TBI with complicated behavioral and/or medical needs. Any health care reform proposal should make sure that these effective and economic alternatives are not excluded because of inappropriate site of service restrictions.

While some individuals with TBI need long-term care, many can function in less intense settings such as group homes or independent living centers. Any standard benefit package should cover long-term care in appropriate settings but should include therapies and programs provided in less costly settings such as independent living centers and other community-based settings including home care. If these settings are not included, there is an incentive for more costly and often inappropriate institutionalization.

It is also important to note that Medicaid in some states, as well as some private insurance companies, are already paying for continuity of care including community-based programs. We do not want to see these excellent programs eliminated and fear that if they are not included in a basic medical benefits package, many of these innovative and effective programs will close.

### Prohibition of Pre-Existing Condition Clauses; Need for Community Rating:

Individuals with TBI are often discriminated against by health insurance carriers through pre-existing condition clauses and through risk based insurance ratings. These practices must stop if individuals with TBI are to obtain access to health insurance at affordable prices.

### Access to Specialists as Gatekeeper Physicians:

If the managed care/gatekeeper approach is part of a reformed health care system, individuals with TBI should be permitted to have a specialist serve as their primary care physician in certain instances. Physicians with specialty training in managing the medical problems of individuals with TBI are often better equipped to serve as the primary care/gatekeeper physician.

### Rehabilitation to Maintain Function:

Rehabilitation should not be limited only to restoring function. Many individuals with TBI need ongoing therapy throughout their lives to prevent loss of function and to allow them to work and live independently. We are just recognizing the problems associated with aging for people who sustained TBI 20 to 30 years ago.

## WHAT A BASIC MEDICAL BENEFITS PACKAGE SHOULD INCLUDE

### Rehabilitation:

We believe that a basic medical benefits package should focus on rehabilitation provided in the most cost effective and efficient manner without limitations based on site. Each TBI is different and unique, and rehabilitation needs to be tailored to the specific needs of the individual. To the extent that a basic benefits package has limits on rehabilitation, either inpatient or out-patient, there must be

flexibility in the system to permit longer periods if necessary to achieve a good outcome. While six to eight weeks of rehabilitation may be adequate for some TBIs, it will not be enough for others.

We believe that rehabilitation services should include the following:

- physical therapy
- occupational therapy
- speech and language therapy
- therapeutic recreation
- neuropsychiatric services
- neurobehavioral-psychological services
- vocational services
- personal assistance services
- ongoing medical services
- long-term care services

#### **Other Medical Benefits:**

**Basic Medical Benefits:** Individuals with TBI often have other physical problems which affect their ability to function. Coverage for basic medical services must also be included.

**Prescription Drugs:** In addition, many individuals with TBI need life long maintenance drugs to control conditions such as seizures. While these prescription drugs may be expensive, they are frequently necessary in order for individuals with TBI to live in the community and be productively employed. Thus, in the long run they are cost effective. Additionally, where appropriate, there should be access to experimental drugs.

**Durable Medical Equipment and Assistive Technology** also play a vital role in allowing individuals with TBI to function in society and earn a living and should be included in a basic medical benefits package.

#### **SUMMARY**

We want to emphasize, in closing, that TBI is a disability that often needs life long therapy if the individual is to live independently and be gainfully employed. Our health care system needs to recognize that it is cost effective in the long run to return an individual to independent living and employment. While this may be an expensive proposition, the alternative of maintaining an individual in an institutionalized setting with no ability to support him or herself through employment is much more expensive to society.

Thank you for the opportunity to present our views.

/tf

April 21, 1993



Mr. KLECZKA. Thank you, doctor. That written testimony will be placed in the record in its entirety, and I say that to all the witnesses. If you don't get a chance to tell the committee all your thoughts, the entire statement will be made a part of this hearing.

Mr. ZITNAY. Thank you.

Mr. KLECZKA. We will now hear from the American Occupational Therapy Association, and welcome its president, Mary Evert.

#### STATEMENT OF MARY EVERT, PRESIDENT, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Ms. EVERT. Thank you very much, Mr. Chairman.

My name is Mary Evert and I serve as president of the American Occupational Therapy Association. Our association was founded in 1917 and represents 46,000 occupational therapists, occupational therapy assistants and students throughout the United States. Our members appreciate this opportunity to share our views on a standard health benefits package.

The association supports fundamental reform of the Nation's health care system, and essential to the success of these reform efforts, in our view, is the development of a benefits package which will provide a broad range of cost-effective, accessible, high-quality health care services.

We believe there should be a focus on those interventions which prevent illness and injury and disease and which minimize disability and dependency. This strategy maximizes our Nation's health care investment and minimizes avoidable expenditures. Toward that end, we believe that occupational therapy and other rehabilitation services should be important elements of any standard core benefits package.

Mr. Chairman, we also believe that the best measure of the quality of health care is the impact it has on those it serves. People who have sustained an injury or illness want to regain their ability to function, to live independently, to return to their jobs, their homes, their schools and contribute to their families and their communities. Occupational therapy enables them to reach these goals. Helping health care consumers achieve their highest level of independence and productivity enhances their quality of life by completing the task begun by modern medical technology.

Occupational therapy is a skilled functionally oriented treatment that is provided to people of all ages who have physical, psychosocial and developmental impairments as a result of illness, injury or disease. Occupational therapy practitioners work with individuals to enable them to overcome performance problems and to reach a maximum level of independent functioning in their everyday lives.

Occupational therapy services include adaptation of an individual's environment at home, school, work or in the community, and also the successful application of assistive technology devices which help consumers to develop or acquire functional skills.

While occupational therapy is considered a necessary service for many of those who have long-term or continuing care needs, the need for OT services extends far beyond these populations. In fact, interventions by occupational therapists range from stimulating feeding reflexes in a premature infant to teaching safety and inde-



pendent living to accident victims. Many common injuries and diseases require occupational therapy to speed recovery, prevent recurrence or rehospitization and restore function.

As an integral component of health care today, occupational therapy services are widely covered under major public health insurance programs and by private third-party payers. They are generally available as inpatient and outpatient hospital services and in various community-based and home health settings. We believe that this precedent of existing coverage in the public and private sectors should guide the Congress as it contemplates design of a core benefits package. As a model to assure broad access and consistency with existing benefits packages, we would recommend to the subcommittee the current delivery settings under the Medicare program in which occupational therapy is provided.

Occupational therapy treatment is cost-effective and can help reduce unnecessary health care costs. Prompt intervention by an occupational therapy professional can often avoid functional impairment, with a resulting reduction in the overall cost of care. A recent study shows that patients that receive occupational therapy were more likely to be discharged to their home environments than to nursing facilities.

This standard or core benefits package that you are contemplating will be a central element in the redesign of our Nation's health care system and will, in large measure, determine whether those reform efforts succeed or fail.

AOTA urges that any benefits package include occupational therapy. It has long been our belief that the best health care in the world is inadequate if it fails to include services that insure that the life that has been saved will be meaningful and productive. Occupational therapy offers that critical link to independence and productivity for millions of Americans.

Thank you very much for this opportunity to testify, and we look forward to working with you in the future.

[The prepared statement follows:]

Testimony of the American Occupational Therapy Association on Health Care Reform and the Composition of a Standard Benefit Package, Presented by Mary Evert, MBA, OTR, FAOTA, President, before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, April 22, 1993.

Mr. Chairman and Members of the Subcommittee:

My name is Mary Evert and I serve as President of the American Occupational Therapy Association. Our organization, which was founded in 1917, represents the professional interests of 46,000 occupational therapists, occupational therapy assistants and students of occupational therapy.

Our members appreciate the Subcommittee providing us with this opportunity to share our views on the composition of a standard health benefits package which may be included in any health care reform initiative considered by the Congress.

The Association supports fundamental reform of the nation's health care system in order to assure access to high quality health care for all Americans and to contain rising costs. We look forward to the recommendations of the White House Task Force on Health Care Reform and to working with the Administration and Congress in crafting a constructive solution to our nation's health care problems.

Essential to the success of these reform efforts is, in our view, the development of a benefit package that will provide a broad range of cost-effective, high quality health care services. We believe such a package should include a focus on those interventions which prevent illness, injury and disease and which minimize or remediate disability and dependency. This type of strategy offers us the opportunity to maximize our nation's health care investment and minimize avoidable expenditures. Toward that end, we believe that occupational therapy and other rehabilitation services should be important elements of any standard or core benefit package available to all Americans.

#### **Occupational Therapy in Today's Health Care System**

Occupational therapy practitioners provide services to millions of people each year in acute care and rehabilitation hospitals, nursing facilities, freestanding clinics, comprehensive outpatient rehabilitation facilities, psychiatric facilities, community mental health centers, industry, school systems, through home health agencies and by independent practitioners.

Occupational therapy is a skilled, functionally oriented treatment that is provided to people of all ages who are physically, psychosocially or developmentally impaired. Occupational therapy practitioners work with individuals to enable them to overcome performance deficits that result from illness, injury or disease and to achieve a maximum level of independent functioning in their everyday lives. Occupational therapy also includes adaptation of an individual's environment at home, work, school or in the community and the selection, design, fabrication and training in the use of assistive technology devices to enable consumers to develop or acquire functional skills.

The occupational therapist's initial focus is on treating that pathology or those impaired functions that preclude independence and productivity. Occupational therapists evaluate and treat:

- Impaired ability to perform daily activities such as self-care, work or leisure skills
- Impaired concentration, attention span, thought organization and problem solving

- Impaired visual-spatial relationships, body schema, figure-ground discrimination, eye-motor coordination and motor planning
- Impaired muscle strength, range of motion and physical endurance

In working with consumers, occupational therapists also seek to prevent or inhibit muscle atrophy, prevent or minimize deformity, increase pain tolerance and enhance the individual's ability to interact with his or her environment. Occupational therapists are also concerned with the psychosocial impairments that frequently result from a patient's illness or trauma.

### **Occupational Therapy is Widely Available Under Public and Private Insurance**

As an integral component of health care today, occupational therapy services are widely covered under major public health insurance programs and in the insurance products offered by private third-party payors. They are generally available as inpatient and outpatient hospital services and in various community-based settings.

The federal Medicare program covers occupational therapy in a range of inpatient and outpatient settings. In addition to hospital-based services, Medicare covers occupational therapy services provided under the auspices of rehabilitation agencies, clinics, nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies and independent practitioners.

State Medicaid programs also cover occupational therapy services in hospital inpatient and outpatient settings, comprehensive outpatient rehabilitation facilities, nursing facilities and when furnished by home health agencies, rehabilitation agencies and independent practitioners. Mandatory Medicaid service categories under which occupational therapy services are provided include hospital inpatient/outpatient and nursing facility settings and under the Early and Periodic Screening, Detection and Treatment (EPSDT) program. Where states have the option to provide coverage of occupational therapy services in other delivery settings, they do so broadly.

In the private insurance market, occupational therapy is viewed as a valuable and cost-effective component of health benefit plans. It is widely covered by Blue Cross-Blue Shield plans and by other insurers under their traditional indemnity and managed care products. Coverage is well established within the HMO market. The annual Health Maintenance Organization Industry Survey conducted by the Group Health Association of America confirms that virtually all HMOs cover occupational therapy as part of their best selling benefit package.

Clearly, occupational therapy services are an integral part of basic health care in America today. The Association believes that this precedent of existing coverage in the public and private sectors should guide the Congress as it contemplates design of a core benefit package.

### **Occupational Therapy Meets The Needs of a Wide Range of Consumers**

While occupational therapy is considered a necessary service for those who have long-term or continuing care needs, the need for these services extends much beyond the long-term care population. In fact, interventions by occupational therapists range from stimulating feeding reflexes in a premature infant to teaching safety and independent living to an accident victim.

Many common injuries, diseases and other impairments require occupational therapy to speed recovery, prevent recurrence or rehospitalization and maximize the restoration of a person's functional capacity. Among these are orthopedic or sports-related injuries and work-related trauma. Other conditions frequently requiring occupational therapy



intervention are burns, spinal cord injuries, head injuries, mental illness, substance abuse, cancer, stroke, arthritis, diabetes and congenital or developmental impairments.

The best measure of the quality of health care is its impact on those who are served. People who have sustained an injury or illness want to regain their ability to function, live independently, return to their jobs or school and contribute to their families and communities. Occupational therapy enables them to reach those goals. Helping consumers achieve their highest level of independence and productivity enhances their quality of life and completes the task that modern medical technology began.

### **Occupational Therapy is Cost-Effective**

Occupational therapy treatment is cost-effective and can help reduce unnecessary health care expenditures. Prompt and appropriate intervention by an occupational therapy professional often can prevent or remediate functional impairment caused by illness, disease or injury with a resulting reduction in the overall cost of care. Specifically, occupational therapy can:

- contribute to a significant decrease in hospital length of stay and help avoid costly rehospitalizations
- reduce the need for institutionalization
- reduce the amount of care and services required after discharge
- prevent complications and further disability
- speed an individual's return to independent and productive living in the community

The value and cost effectiveness of occupational therapy and related services in rehabilitating those who have sustained injuries or illnesses is underscored by a variety of studies and surveys conducted over the years. For example, a recent study determined that patients who received occupational therapy were more likely to be discharged to home environments than to nursing facilities. In a broader review on the effectiveness of rehabilitation, a survey conducted by the Health Insurance Association of America (HIAA) of member companies reported a savings of \$11 for every \$1 spent on rehabilitation, with "a savings per claimant ranging from \$1,500 to over \$250,000." Other reports substantiate even more significant cost-savings.

### **Conclusion**

The composition of a standard or core benefit package is a central element in the redesign of our nation's health care system and will, in large measure, determine whether those reform efforts succeed or fail. The Association urges that any benefit package include coverage of occupational therapy services in the full range of inpatient and outpatient settings, including community-based and home settings. As a model, we recommend to the Subcommittee the current delivery settings in which occupational therapy services are covered under the Medicare program. This coverage model would provide consumers with broad access to these services and would assure consistency with the precedent of existing public and private health insurance programs.

It has long been our belief that the best health care in the world is inadequate if it fails to include services to ensure that the life that medical intervention has saved will be meaningful and productive. Occupational therapy services are that critical link to independence and productivity for millions of Americans.

Again, we thank you for the opportunity to present our views, and we look forward to working with the members of this Subcommittee in the months ahead as you continue your deliberations on the critically important issue of health care reform.



Mr. KLECZKA. Thank you very much, Ms. Evert, for your testimony.

The National Association for Home Care and Hospice Association of America is represented by Margaret Cushman. Ms. Cushman, we welcome you.

**STATEMENT OF MARGARET CUSHMAN, SECRETARY, BOARD OF DIRECTORS, NATIONAL ASSOCIATION FOR HOME CARE; AND HOSPICE ASSOCIATION OF AMERICA; AND PRESIDENT AND EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION GROUP, INC., PLAINVILLE, CONN.**

Ms. CUSHMAN. Thank you.

My name is Margaret Cushman and I am the chief executive officer of visiting nurse and home care serving greater Hartford and Waterbury, Conn. I am here representing the National Association of America and our multitude of members and providers and the individuals that we serve.

Both organizations have long advocated the development of a national plan to insure universal access to basic acute care and long-term care services. We believe that no health care reform proposal is complete without access to quality home care and hospice for both acute and long-term care needs. These vital services provide millions of individuals the aged, infirmed, disabled and children, the ability to receive care in the settings that allow them the greatest satisfaction, independence and dignity, their home.

There are five primary components crucial to the successful provision of home care and hospice services. First, a broad spectrum of skilled and nonskilled services must be covered, to enable individuals to stay in their home. Second, eligibility for services should be based on an individual's need, not on an age or arbitrary condition such as prior hospitalization. Third, any case management provision that is included should enable providers to retain and remain responsible for care management, while payers deal with utilization review and cost containment issues. Fourth, health care reform must incorporate strong quality assurance mechanisms and include standards for skilled and nonskilled service provisions.

Health care reform legislation must address the need for access to both basic health services and coverage, including home care and hospice, and a comprehensive array of the long-term care services centered around care in the home. Home care and hospice have proven to be efficient, cost-effective and appropriate options for millions of patients who require services because of acute illness, disability, long-term care and terminal illness. They have become standard benefits in current employer plans. Over 80 percent of all employee health care plans currently cover both home care and hospice.

Including home care, both acute and hospice, as a basic health benefit is good for patients who want to remain with their families while they are ill, and it is good for payers who want to provide quality care that is cost effective in an appropriate setting. There have been numerous studies done by insurance companies and others showing the thousands of dollars that can be saved for cases, taking advantage of cost-effective appropriate home care.

Finally, any action on health care reform must include comprehensive long-term care. Between 9 and 11 million Americans of all ages require long-term care because of chronic illnesses. We have heard some very moving examples earlier in this panel. Long-term care and hospice are humane, they reinforce and supplement the care provided by family members and friends, while maintaining dignity and independence.

I appreciate the opportunity to testify today, and I commend the Ways and Means Committee for holding this hearing. Our National Association for Home Care and Hospice Association support enactment of health care reform plan which includes containment of health care cost, while achieving universal access.

Thank you.

[The prepared statement follows:]

**STATEMENT OF MARGARET CUSHMAN, PRESIDENT AND EXECUTIVE  
DIRECTOR, THE VISITING NURSE ASSOCIATION GROUP, INC., PLAINVILLE,  
CONN., ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE AND  
HOSPICE ASSOCIATION OF AMERICA**

My name is Margaret Cushman. I am representing the National Association for Home Care (NAHC) and its affiliate, the Hospice Association of America (HAA), which represent the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC and HAA are committed to assuring the availability of humane, cost-effective, high-quality home care and hospice services to all individuals who require them. Toward this end, NAHC and HAA have long advocated the development of a national plan to ensure universal access to basic acute care and long-term care services.

I am very pleased to be here today to give the Ways and Means Health Subcommittee our suggestions on reforming the U.S. health care system.

In my comments today, I will outline several specific recommendations to ensure the appropriate inclusion of home care and hospice services in health care reform proposals. We believe that no health care proposal is complete without ensuring access to high quality home care and hospice in both the acute and long-term care setting. These vital services provide millions of individuals -- the aged, infirm, disabled, and children -- the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity -- in their homes.

**SUMMARY INFORMATION AND RECOMMENDATIONS**

The health care crisis looms as one of the most serious and urgent challenges facing our country. Health expenditures are increasing twice as fast as other sectors of the economy and are expected to exceed \$800 billion this year. Despite this extraordinary commitment of resources, access to basic health care and long-term care services remains a problem for millions of Americans.

Nearly one in four nonelderly Americans lacks access to basic health care services either because they have no health insurance coverage or because the insurance they do have is inadequate to meet their needs. Long-term care poses an even greater problem. Millions of Americans of all ages need long-term care services and little help is available through federal or state programs.

Public demand for a federal solution to the health care crisis played a key role in many of the recent election campaigns and elicited promises for action on the issue this year. As the new Congress and Clinton Administration begin working on the complex facets of health care reform, an important component of their deliberations will be the provision of home care and hospice services. To ensure adequate access to these services, the National Association for Home Care and the Hospice Association of America offer the following recommendations:

- Acute care basic benefit packages must include home care and hospice services;
- Any reform plan enacted must include a long-term care component;
- In-home services provided under both acute care and long-term care benefits must be designed to ensure individuals access based on need and not age or other arbitrary conditions such as prior institutionalization;

- Mechanisms for eligibility determination and patient management must recognize the importance of provider participation;
- Safeguards should exist for quality assurance and cost containment; and
- Financing for the health reform plan must be progressive and broadly based.

#### BASIC BENEFIT PACKAGES MUST INCLUDE HOME CARE AND HOSPICE SERVICES

Although national health care reform proposals span the ideological spectrum from a minor modification of the existing system to a more radical overhaul, one common denominator is the specification of a basic set of health care benefits that must be provided to all beneficiaries. It is crucial that home care and hospice services be included in these basic benefit packages. Home care and hospice services have proven to be efficient, cost effective and appropriate options for millions of patients who require such services because of acute illness, long-term health conditions, permanent disability and terminal illness.

**Federal Programs.** The importance of home care as an acute care benefit has been recognized by Medicare since its inception and as a required benefit in Medicaid since 1970. Congress included home health care under Medicare posthospital benefits as an "important additional benefit" that could provide an "alternative to costly institutional care."<sup>1</sup> In 1980, Congress eliminated the prehospitalization requirement, recognizing home health care as an appropriate, cost effective point of entry for acute care services.<sup>2</sup> Also in 1980, Congress eliminated the arbitrary limit on the number of allowable visits. In addition, federal requirements for health maintenance organizations (HMOs) have since 1973 mandated the provision of home health services "without limitation as to time or cost."<sup>3</sup> Home care services have become even more important with the advent of Medicare DRGs which have resulted in earlier discharges of higher acuity patients to home health care.<sup>4</sup>

Hospice services, including medical palliative and social supportive services, were added to the Medicare program in 1983 and made an option under Medicaid in 1986, as cost effective services for terminally ill patients. To date, 35 states have chosen to include hospice in their Medicaid programs.

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<sup>1</sup>S.Rept.89-404, Part I, p. 26; H.Rept. 89-213, p. 23.

<sup>2</sup>The prehospitalization requirement was required for Part A but not Part B home health services.

<sup>3</sup>Health Maintenance Organization Act of 1973, 42 USC §300e(b); §300e-1(1)(G).

<sup>4</sup>Approximately 18 percent of all Medicare hospital patients are discharged to home health care according to an Abt Associates study cited in Health Care Financing Review, 1988 Annual Supplement. In 1981, only 9 percent of Medicare hospital patients were discharged to home health care.



**Employer-Sponsored Health Insurance.** The Pepper Commission and many other health care reform plans that rely on employer-sponsored health insurance would require a basic benefits package that would be comparable with what employees are currently receiving. It is important to note that home care has become a standard benefit in current employer plans. A 1990 survey by the Health Insurance Association of America found that 83-89 percent of insured employees had coverage for home care services.<sup>3</sup> Likewise the Bureau of Labor Statistics found that 75-79 percent of full-time workers participating in employer-sponsored health plans in medium and large establishments had coverage for home health care in 1989 compared with only 46 percent in 1985.<sup>4</sup> Both surveys also found hospice services to be a widely available benefit. The dramatic growth in coverage for hospice services from 11 percent of insured employees in 1984 to over 80 percent in 1990 indicates hospice is fast becoming a standard acute care benefit.

Percent of Insured Employees with Coverage for Home Care and Hospice, by Type of Employer-Sponsored Insurance Plan, 1990		
	Home Care	Hospice
Conventional	83%	82%
PPO	89	87
IPA HMO	89	80
Staff/Group HMO	86	72
Source: HIAA Employer Survey, 1990		

Percent of Insured Employees Covered for Home Care and Hospice Services through Employer-Sponsored Plans, Selected Years			
	Medium and Large Private Establishments		Small Private Establishments
	1984	1989	1990
Home Care	46%	75%	79%
Hospice	11%	42%	51%
Source: U.S. Department of Labor, Bureau of Labor Statistics, as reported in BLSI Issue Brief No. 128, August, 1990.			

**State Requirements for Home Care and Hospice.** State governments also have increasingly recognized the importance of acute care home care and hospice benefits. One manifestation is state mandates for the inclusion of home care and hospice in private insurance

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<sup>3</sup>Health Insurance Association of America, Employer Survey, 1990.

<sup>4</sup>U.S. Department of Labor, Bureau of Labor Statistics, as reported in Employee Benefit Research Institute Issue Brief No. 128, August, 1990.

policies. Currently 18 states mandate the provision of home care benefits; seven require the inclusion of hospice services.<sup>7</sup> In addition, numerous state reform plans to improve access either through private insurance reform or more comprehensive measures have recognized home care and hospice as acute care benefits. Even when states have looked at eliminating mandated benefits in order to enable companies to offer less expensive insurance products, they have repeatedly either kept the home care and hospice mandates or required products that are exempt from the mandates to include a core set of benefits that includes home care.

**Social Security Advisory Council.** Additional support for the concept of in-home acute care benefits can be found in the 1991 report of the Social Security Advisory Council on Health Care Reform.<sup>8</sup> Although the bipartisan group did not achieve consensus on the best approach to health care reform, its members did agree that home care services should be included in the minimum benefit packages outlined in its recommended prototype plans.

**Congressional Proposals.** Numerous Congressional proposals introduced last year also included acute home care and hospice benefits in their basic benefit packages. For example Ways and Means Chairman Dan Rostenkowski (D-IL) introduced a national pay-or-pay plan that would require employers to offer minimum benefits, including home health and hospice care, equivalent to that currently offered under Medicare, or pay into a public program which would provide Medicare-like benefits to all not covered on the job or by Medicare. Health Subcommittee Chairman Pete Stark (D-CA) introduced a social insurance plan whose home care, hospice care and other acute care benefits mirrored those provided under Medicare. Congressmen John Dingell (D-MI) and Henry Waxman (D-CA), who chair the Energy and Commerce Committee and its Subcommittee on Health, jointly introduced a universal access plan whose basic benefits included home care and hospice services. Senator Bob Kerrey (D-NE) also sponsored a social insurance-type reform plan that included acute care home health and hospice benefits.

The inclusion of acute home care and hospice services as a basic health care benefit is good for both the beneficiaries -- who want to remain with their families during times of illness -- as well as the payor or payors -- who want to provide high-quality care in the most appropriate and cost effective setting. Aetna Life & Casualty has reported a \$78,000 per-case savings by using home care for victims of catastrophic accidents. Lewin/ICF studied differences in the cost and effectiveness of inpatient care plus home care versus

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<sup>7</sup> States mandating home health: Arizona, California, Colorado, Connecticut, Florida, Kentucky, Maine, Maryland, Massachusetts, Montana, Nevada, New Mexico, New York, Rhode Island, Texas, Vermont, Washington and Wisconsin. States Mandating Hospice: Colorado, Maryland, Michigan, Montana, Nevada, New York and Washington.

<sup>8</sup>The Social Security Advisory Council is mandated by the Social Security Act to meet every four years and review the long-range financing of Social Security and Medicare and the impact of these programs on public assistance programs authorized by the Act. The 1991 council focused on reform strategies to improve access to acute health care and long-term care services.

less inpatient care and more home care for patients hospitalized with a hip fracture, chronic obstructive pulmonary disease (COPD), and amyotrophic lateral sclerosis (ALS) with pneumonia. It found that for all three diagnoses, cutting inpatient days and substituting more home care days reduced costs by \$2,300 for hip fracture patients, \$520 for COPD patients, and \$300 for ALS patients."

Perhaps the importance of acute home care services is best illustrated by a recent case handled by NAHC's Center for Health Care Law. Christopher Klemmer of Reading, Pennsylvania, was hospitalized at the age of six months with an enlarged aorta that was severely restricting his ability to breathe. He spent the next 155 days in the hospital. Christopher needed a special tracheostomy tube and a ventilator to prevent his airway and bronchi from collapsing. JoAnne, his mother, stayed at the hospital with him while her husband, Gary, who had been laid off from his job, remained at home with their four other children.

When Christopher's condition stabilized, Gary and JoAnne wanted to take him home so their family could be together and live as normal a life as possible. However, they discovered that their insurance would not pay for medical care that Christopher continued to need unless he were in a hospital. Their choices were limited -- they didn't want to leave Christopher in the hospital, where the insurance company would cover his costs, but they couldn't afford to bring him home and purchase private in-home skilled nursing services.

The Center for Health Care Law learned of the Klemmer's dilemma and offered to help. After several months of negotiations, the Klemmer's insurance company finally agreed to exchange Christopher's hospital benefits for home care. Pennsylvania's Medicaid waiver program also will cover part of Christopher's care.

Both Medicaid and the private payor will realize tremendous cost savings by allowing this exchange. Instead of paying for hospitalization in an intensive care unit at nearly \$3,000 a day, home care will now be provided for less than \$800 a day. Christopher will receive in-home respiratory therapy and private duty nursing services. Under a universal access plan whose basic benefits included home care services, a family facing a situation like the Klemmer's would not have to seek legal help to obtain the more appropriate and less expensive home care services; and their son could go home much earlier.

#### REFORM PLANS MUST ADDRESS NEED FOR LONG-TERM CARE

Any action taken on health care reform must not overlook the growing need in the U.S. for a comprehensive long-term care program. It is impossible to separate the need for reform of the current health care system without also addressing the need to include a long-term care component.

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"Economic Analysis of Home Medical Equipment Services," May 29, 1991, Lewin/ICF, Washington, DC.

Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million. The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthweight children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Spending for long-term care is currently estimated at \$57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-term care. Many families exhaust their emotional and financial resources providing and purchasing long-term care. A million Americans a year go bankrupt trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

It is clear that swift and comprehensive reform along the lines of the recommendations proposed in 1990 by the Pepper Commission will be necessary to address the nation's long-term care problem. The Pepper Commission report was historic. Both liberals and conservatives of both parties in an 11-4 vote reached a consensus on the significance of the long-term care problem and outlined a blueprint for a national solution. The Pepper Commission appropriately targeted home care and hospice as the best answers to the nation's long-term care needs. Long-term home care and hospice improve the quality of life because they are more humane. They reinforce and supplement the care provided by family members and friends and maintain the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care services can also be cost effective. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of \$1,100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs \$1,000 a month for home care compared to \$2,100 a month for skilled nursing facility care, according to the program director. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.<sup>10</sup>

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<sup>10</sup>State Health Notes, Intergovernmental Health Policy Project, George Washington University, Washington, DC, June 1992[13:135].



The National Governors' Association (NGA) has recognized the importance of home care services and in a resolution adopted in 1992 stressed the importance of making home and community-based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost effective method of care.

#### PRIMARY COMPONENTS OF HOME CARE AND HOSPICE BENEFITS

There are five primary components that are crucial to the successful provision of home care and hospice services: the scope of benefits, eligibility requirements, eligibility determination and patient management, safeguards for quality assurance and cost containment, and financing.

**Scope of Benefits.** The home care and hospice services must cover a spectrum of skilled and nonskilled services that enable individuals to stay in their own homes. A recommended definition under an acute care component would include skilled nursing, personal care services such as those provided by a home care aide, physical therapy, occupational therapy, speech pathology, and medical social services as well as the concomitant assistive devices and minor home adaptations that enable beneficiaries to receive services at home. All these skilled services should be covered under a long-term care benefit in addition to a broad array of nonskilled services such as chore services, respite care, adult day care, transportation services, training of unpaid or family caregivers, and nursing home care for a limited time with the primary purpose that individuals would return to their homes. The distinction between acute care benefits and long-term care benefits should not be so rigid as to inhibit the smooth coordination of in-home services.

**Eligibility Requirements.** Eligibility for services should be based on an individual's need for services and not on age or other arbitrary conditions such as prior institutionalization. A medical necessity trigger could be used to qualify beneficiaries for the primarily skilled services provided under an acute care benefit. Under the long-term care benefit, eligibility should be granted to individuals who need assistance to perform activities of daily living (i.e., eating, transferring, toileting, dressing, and bathing) because of functional or cognitive disability. While many of the legislative proposals for long-term care have recognized activities of daily living (ADLs) eligibility triggers, some have required an individual to need assistance with as many as three ADLs before becoming eligible for services. In considering ADLs, it is important to note that an individual unable to carry out even one ADL can be extremely disabled and in need of long-term care. For example, an elderly individual, living alone with no family or other caregiver closeby, who needs assistance with only one ADL, such as eating, would benefit greatly from a relatively small amount of long-term home care.

**Eligibility Determination and Patient Management.** There are many different opinions on the best way to structure these "case management" services. A system using external case management may result in a highly bureaucratic structure that creates an unnecessarily costly and administratively burdensome duplication of client care planning and review functions. For example, external case management would add 20 percent (\$4 billion) to the cost of a long-term care plan based on the Pepper Commission recommendations. Home care providers and hospices are uniquely qualified to manage clients' care and serve as the clients' advocates. Agency caregivers are specially trained for assessments and are in personal contact with the client on a continuing basis. They are the ones ultimately responsible to the client for his or her care. The recommended case management structure would enable the provider to remain responsible for care management while allowing the payor to carry out its utilization review responsibilities. This structure has been successfully implemented in New York State's Nursing Home Without Walls program, which has made use of joint assessment visits by professionals representing provider and payor. Another example is the use of the interdisciplinary team within the Medicare hospice benefit as a form of case management. A prior approval for the utilization of services, after an assessment has been done by the home care agency or hospice who provides a plan of care, could also serve as an effective safeguard.

**Safeguards for Quality Assurance and Cost Containment.** Health care reform plans should not overlook the need for quality assurance mechanisms. Foremost among these are standards for service providers. Appropriate standards for organizations delivering in-home skilled services can be found in the Medicare Conditions of Participation for home care and hospice. For nonskilled service providers, suitable standards can be based on the requirements developed by the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the National HomeCaring Council, which have developed special standards for training, testing and supervision of paraprofessional workers employed by home care aide organizations. These provider standards serve as important protections for consumers.

**Financing.** Any revenue-raising mechanism enacted should be as progressive and as broad-based as possible and should be designed to keep pace with benefit growth. There are a variety of revenue-enhancement measures that meet this test. Further revenue might come from increases in the high-income tax rate or so-called "sin" taxes on alcohol and cigarettes.

Private long-term care insurance may be a partial solution for financing long-term care in that it can protect some people against large out-of-pocket expenses. And federal standards for private insurance could help make these products even more viable. However, for the most part, private long-term care insurance is not affordable for the elderly or people who are already disabled and it has not had appeal for younger, healthy people who can afford the premiums.

#### **SUMMARY**

Inadequate access to acute health care and long-term care is the single most devastating problem facing America. And this problem will only get worse unless prompt action is taken. Reform legislation must address the need for access to both basic health care coverage, including home care and hospice services, and a comprehensive array of long-term care services based on home care and hospice.

Without federal reform, health care costs will continue to increase while access to basic services and long-term care services deteriorates. Congress should make the most of the current climate of support for change and make health care reform a top priority for action.

The National Association for Home Care and Hospice Association of America support enactment of a health care reform plan that will contain the increases in health care costs while achieving universal access to high quality care.



Mr. KLECZKA. Thank you very much for your testimony.

Mr. Pyles, representing the National Home Health Services Alliance. We welcome you.

# **STATEMENT OF JAMES C. PYLES, ON BEHALF OF THE NATIONAL HOME HEALTH SERVICES ALLIANCE**

Mr. PYLES. Thank you, Mr. Chairman. I am glad to be here today.

Members of the subcommittee, I am James C. Pyles. I am appearing on behalf of the National Home Health Services Alliance, which is a cooperative alliance of all types of home health service providers and it includes participation by representatives of both national and State home health associations.

My primary purpose for seeking to testify before the subcommittee is to set forth the reasons why home health services must be included as a core acute care health service in any health reform legislation. While the alliance supports the inclusion of home health care in any legislation providing for long-term care, we wish to emphasize that home health services are and should remain an indispensable element of acute health services. Inclusion of home health services as a statutorily prescribed standard benefit provides one of the best methods of achieving the primary objectives of health reform—controlling costs and enhancing access.

Increasingly, acute health care services and therapies are being provided in the home, thereby shortening or completely eliminating expensive institutionalization. Those services and treatments include skilled nursing care, speech, occupational and physical therapy, chemotherapy, AIDS treatment and other services.

Home health services can be used to provide immediate access to underserved populations, whether they are inner-city Oakland, New York City or rural Texas. The services can be expanded or contracted infinitely to meet the existing need. Home health services currently are a core acute care benefit under both government and private health insurance programs. They are included under the Medicare program and the Medicaid program. Nearly 100 percent of HMO enrollees have home care coverage. Nearly 100 percent of employees covered under employer financed programs also have coverage for home health services.

Home health should be regarded as a preventive and cost containment service and coverage should be based exclusively on medical necessity. Patients should not be discouraged from electing these lower cost services by the imposition of arbitrary restrictions, such as coinsurance payments, prior hospitalization requirements and visit limits.

The cost of home health services should not be increased needlessly by the imposition of a layer of bureaucracy in the form of third-party case managers. Home health agencies routinely provide case management services in the private sector and are required by Medicare law to coordinate all care received by Medicare patients, regardless of source. Thus, health care reform legislation should permit home health agencies to continue providing case management services which they have been providing successfully for many years.



Market access by all types of providers, nonprofit, proprietary and hospital based, is just as crucial to successful health care reform as access to health care by individuals. The opportunity to participate in managed care and other types of health delivery plans must be based upon objective criteria, with due process rights available for those who are excluded. There must also be rigorous enforcement of the antitrust laws and the self-referral laws. With all health care brought under a single system for the first time in the Nation's history, the danger of eliminating competition is particularly acute. Only by preserving market access for all types of providers, can we encourage innovation and insure that individuals continue to have a choice of high-quality cost-effective providers.

Any health reform plan should insure that the government, as well as providers, operate more cost efficiently and effectively. Clear and consistent national standards should be established for coverage, payment and quality assurance, with an efficient and effective and unbiased appeals process. In issuing regulations, Federal agencies should be required to consider whether more cost-effective alternatives exist.

Finally, a provision should be included which requires the cost-effectiveness of all Federal regulation of health care providers to be coordinated through a single agency within the Department of Health and Human Services. As a judge of the seventh circuit court of appeals recently stated, in striking down the OSHA blood-borne pathogens rules for home health agencies, Congress must assume its responsibility for increasing the cost of health care, if it fails to coordinate the regulation of health care providers.

In summary, inclusion of home health services as an acute care benefit offers the best opportunity of controlling health care costs and increasing access, while preserving the dignity and independence of patients.

I would add one further thing, in response to the question that was asked by Chairman Stark earlier regarding who should design the basic benefits package. We strongly believe Congress should design that. This is a decision that is just too important to be left in the hands of an unelected and unaccountable national health board.

Thank you.

[The prepared statement follows:]

## STATEMENT OF JAMES C. PYLES, ON BEHALF OF NATIONAL HOME HEALTH SERVICES ALLIANCE

Chairman Stark and members of the Subcommittee:

I am James C. Pyles, and I am appearing on behalf of the National Home Health Services Alliance, which is a cooperative alliance of all types of home health service providers and includes participation by representatives of both national and state home health associations.<sup>1</sup>

My primary purpose for seeking to testify before the Subcommittee is to set forth the reasons why home health services must be included as a core acute care health service in any health reform legislation. I would further like to dispel the misunderstanding that has developed among some members of Congress and the Administration that home care is essentially a long term care service. While the Alliance supports the inclusion of home care in any legislation providing for long term care, we wish to emphasize that home health services are, and should remain, an indispensable element of acute health services.

Inclusion of home health services as a statutorily prescribed standard benefit provides one of the best methods of achieving the primary objectives of health reform -- controlling costs and enhancing access. Increasingly, acute care services and therapies are being provided in the home, thereby shortening or completely eliminating expensive institutionalization. Those services and treatments include the following:

- skilled nursing care
- personal care provided by home health aides
- speech, occupational, or physical therapy,
- medical social services,
- chemotherapy,
- IV antibiotic therapy,
- parenteral and enteral nutritional therapy,
- respiratory therapy,
- AIDS treatment,
- care for premature and low birth weight infants,
- high risk pregnancy monitoring,
- care for head and spinal cord injuries,
- mental health and psychiatric care, and
- hospice care for the terminally ill.

Home health services can be used to provide immediate access to underserved populations whether they are in inner city Oakland, New York City or rural Texas, and the services can be expanded or contracted to respond to changing need.

Home health services currently are a core acute care benefit under both government and private health insurance programs. The Medicare program has covered home health as an acute care service since its enactment in 1965, and the Medicaid program has included coverage since 1970.<sup>2</sup> Nearly 100% of HMO enrollees have coverage for home health services.<sup>3</sup> Eighty-five percent of employees

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<sup>1</sup> Participating associations include the American Federation of Home Health Agencies, the Home Health Services and Staffing Association, the Visiting Nurse Associations of America and the National Association for Home Care Forum of State Associations.

<sup>2</sup> Section 102(a) of the Social Security Amendments of 1965, 42 U.S.C. § 1395d(a)(3); 42 U.S.C. § 1396d(a)(7).

<sup>3</sup> HMO Industry Profile, 1992 Edition, p.4.

covered by employer sponsored health plans receive coverage of home health services, and ninety percent of Blue Cross/Blue Shield plans cover home health services.<sup>4</sup>

Home health should be regarded as a preventive and cost containment service, and coverage should be based exclusively on medical necessity. Patients should not be discouraged from electing these lower cost services by the imposition of arbitrary restrictions such as coinsurance payments, prior hospitalization requirements, and visit limits.

The cost of home health services should not be increased needlessly by the imposition of a layer of bureaucracy in the form of third party case managers. Home health agencies routinely provide case management services in the private sector, and are required by Medicare law to coordinate all of the care received by Medicare patients regardless of the source.<sup>5</sup> Thus, health reform legislation should permit home health agencies to continue providing the case management services which they have been providing successfully for years.

Market access by all types of providers — nonprofit, proprietary and hospital-based — is just as crucial to successful health reform as access to health care by individuals. The opportunity to participate in managed care and other types of health delivery plans must be based upon objective criteria with due process rights available for those that are excluded from those plans. There must also be rigorous enforcement of the antitrust and self referral laws.<sup>6</sup> With all health care brought under a single system for the first time in the nation's history, the danger of eliminating competition is particularly acute. Only by preserving market access for all types of providers can we encourage innovation and ensure that individuals continue to have a choice of high quality, cost effective providers.

Any health reform plan should ensure that government as well as providers operate more cost effectively. Clear and consistent national standards should be established for coverage, payment and quality assurance with an efficient and unbiased appeals process. In issuing regulations, federal agencies should be required to consider whether more cost effective options exist.

Finally, a provision should be included which requires the cost effectiveness of all federal regulation of health care providers to be coordinated through a single agency within the Department of Health and Human Services. As a judge of the Seventh Circuit Court of Appeals recently stated in striking down the OSHA bloodborne pathogens rules for home health agencies, Congress must assume its

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<sup>4</sup> Health Industry Association of America, Employer Survey, 1990.

<sup>5</sup> 42 C.F.R. § 484.14(g) and 484.18(a).

<sup>6</sup> As the late Justice Thurgood Marshall stated, "Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete -- to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster." United States v. Topco Associates, Inc., 92 S. Ct. 1126, 1135 (1972).

responsibility for increasing the cost of health care if it fails to coordinate the regulation of health care providers.<sup>7</sup>

In summary, inclusion of home health services as an acute care benefit offers the best opportunity of controlling health care costs and increasing access while preserving the dignity and independence of the patients.

Attachment

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<sup>7</sup>

Home Health Services and Staffing Association v. Martin, C.A.No. 92-1482, at p.49 (7th Cir., January 28, 1993).



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## *National Home Health Services Alliance*

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"Any Health Care Reform Must Include Home Care as a Core Benefit --  
Because Home Health Care Is Part of the Solution."

Phone: 301/588-1454 or 703/836-9863  
Fax: 301/588-4732 or 703/836-9866

### HEALTH CARE REFORM:

#### HOME HEALTH IS PART OF THE SOLUTION

The National Home Health Services Alliance urges the Clinton Administration and Congress to recognize home health services as a key component in reform of our nation's health care system.

Home health is much more affordable than inpatient care and a majority of Americans now have access to home care as a basic benefit. Home care is an existing foundation on which a reformed health care system can be built.

Inclusion of home health as a key cost-saving component of most insurance plans indicates that home health care makes good economic sense to the private sector. It should also make economic sense to the new Administration and Congress to maintain home care as an essential part of the nation's health care system. This means that home care must be part of any mandated minimum benefits package contained in managed competition legislation or any other health care reform legislation.

### Americans Prefer Home Health Care

Home health care is the choice of consumers and is the preferred modality of care. In many rural and underserved areas of the country, home care is the health care delivery infrastructure, the only access to health care services, even for patients who are not homebound. Home health is preferred because it is humane. It maximizes independence and dignity for those unable to leave home for services.

Home care keeps our parents and grandparents out of nursing homes. It brings our at-risk babies home from the hospital, and it enables families to care for chronically ill children in the home. It enables disabled family members and neighbors to remain independent, at home, and in their communities.

Home health care is preferred because it permits earlier discharge from the hospital or eliminates hospitalization altogether, and facilitates an earlier return to work. Most importantly, studies show that individuals recover more quickly and their potential is maximized at home, whether they are being treated for an acute, chronic, or catastrophic illness.

### Home Health Is Ready to Respond

Home health care constitutes the most viable opportunity for curbing our nation's bill for health care in the coming years as access to health care coverage is extended to more Americans.

Because of their large numbers, baby boomers will require more health care services as they age. More low birthweight babies will survive, but with disabilities, and in need of continuous preventive care. The HIV-infected population will increase exponentially. Technology development has enabled home care to respond by making possible provision of services in the home which were available only in hospitals ten years ago. These services include:

- chemotherapy
- IV antibiotic therapy
- parenteral and enteral nutrition therapy
- respiratory therapy
- AIDS treatment
- premature and low birthweight infant care
- high-risk pregnancy monitoring
- head and spinal cord injury care
- hospice care for the terminally ill

### Home Care Is Already a Key Part of Our Health System

Employers and private insurers recognize the cost effectiveness and quality of home health care through its inclusion as a standard benefit in health insurance plans:

- The Blue Cross and Blue Shield Association of America reports that 90 percent of Blue Cross Blue Shield plans included home health in traditional benefit packages in 1990, up from only 46 percent in 1974.
- The Health Insurance Association of America found that in 1990 home care coverage existed for 83 percent of insured employees in conventional health plans and 86-89 percent in HMOs and PPOs.
- Data from the Bureau of Labor Statistics indicate that 75 percent of insured employees of medium and large employers had home health coverage in 1990 compared to 46 percent in 1984; BLS also found that 79 percent of covered employees in small businesses had home health coverage in 1990.

The Blue Cross and Blue Shield Association states that its members' policies contain home health services because such care

reduces hospital stays, leads to shorter recovery time, and produces a better patient psycho-social outlook. Business and Health magazine, published by the Washington Business Group on Health, reported in April, 1992, that "Savvy employers can save thousands of dollars by judiciously using home health care instead of hospital care ... Employers and insurers are taking advantage of home health care benefits as never before by expanding home care's traditional role of being used only for after-hospital care to using it to prevent hospitalization.

The Federal Government recognizes the vital role of home health care. Medicare has included home care as an acute benefit since its inception in 1965. Congress expanded availability in 1980 by eliminating the prior hospitalization requirement and limit on the number of visits. Medicaid has required states to include home care services since 1970. Federal requirements for HMOs have mandated provision of home health since 1973.

Home care has strong bi-partisan support in Congress. Republicans and Democrats both recognized the role of home care in health care reform legislation introduced in the 102nd Congress. Key committee and subcommittee chairmen in the House of Representatives, including Congressmen Dan Rostenkowski, Pete Stark, John Dingell, and Henry Waxman, included home health as a core benefit in their respective bills.

### Home Health Care Is Cost Effective

The cost effectiveness of home health care is indicated by a number of studies, including the following:

- The Visiting Nurse Service of New York has an average daily census of 1,150 AIDS patients in its At Home Options Program (AHOP) for Empire Blue Cross Blue Shield subscribers. A preliminary study indicates that while receiving home care, AHOP participants each incurred \$5,068 less for inpatient admissions, \$720 less in outpatient institutional claims, and \$347 less in hospital-related home care costs than non-participants.
- A Lewin/ICF study found considerable savings per episode for three different diagnoses when hospital care is used in conjunction with home care rather than without it. The home health/hospital savings per episode are as follows:
  - hip fracture - \$2,300
  - amyotrophic lateral sclerosis with pneumonia - \$300
  - chronic obstructive pulmonary disease - \$520

The study indicated that annual savings for just these three diagnoses would be \$624 million.

- U.S. News & World Report, on January 25, 1988, reported dramatic savings for a number of types of patients through use of home care services, including the following costs per patient:
  - chemotherapy - \$10,500 per month in the hospital versus \$3,500 per month at home
  - tube feeding - \$16,600 per month in the hospital versus \$6,000 per month at home
  - spinal injury - \$23,800 per month in the hospital versus \$13,900 per month at home
- Aetna Life & Casualty Co. has reported a \$78,000 per case saving for victims of catastrophic accidents through its Individual Care Management Program utilizing home health services.
- Aetna, in 1986, indicated significant savings by treating newborns with breathing and feeding problems in the home; the cost was \$20,000 per month with home care compared to \$60,000 per month in the hospital setting.
- Aetna also reported in 1986 that it saved \$200,000 a year per case by treating technology-dependent children in their homes. At home care averaged \$50,000 compared to \$250,000 in the hospital.
- The Center for Health Care Law reported in 1992 that Blue Cross Blue Shield of Harrisburg, Pennsylvania, realized a savings of \$2,200 per day through care of ventilator-dependent children at home compared to hospital services.
- In a study conducted in one Veterans Administration hospital, as reported in Health Services Research in 1992, terminally ill patients were randomly assigned to an experimental group receiving home care and to a control group receiving traditional care. While there was no difference in survival rates, patients in the home care group reported higher satisfaction than those without home care. Participants in the home health group were hospitalized an average of 5.9 fewer days in a six-month period and had costs that were 18 percent lower.

#### **Home Health Agencies Are Also Managers of Care**

Home health agencies have a record of successful and cost-effective coordination of health care and social support services in the community setting. In accordance with their legal mandates under the Medicare and Medicaid programs, home health agencies



already provide assessment and care management for their patients. In fact, the Medicare home health benefit was expanded in 1989 to include "Skilled Management and Evaluation of Care Plan" as a separate reimbursable nursing service.

In any health care reform legislation that it enacts, Congress must permit any qualified organization -- public or private, non-profit or for-profit, provider or non-provider -- to participate as a case manager or managed care provider. Established standards of professional performance and the capacity to perform interdisciplinary assessments must be the qualifying criteria for case management organizations, not tax or provider status. Congress should not take the extreme measure of excluding health care providers who are currently familiar with, and providing, assessment and care management.

A case management system must be developed that will:

- target case management only to those who need such services;
- limit unnecessary expenditures for case management services;
- prevent creation of an unneeded layer of bureaucracy;
- prevent bottlenecks to care which occur when there is a single model of entry into, and management of, the health care system;
- use the skills of experienced health care professionals who are monitored for the quality of the care they provide, including their case management services;
- ensure that the relationship between the caregiver and the provider is maintained without third-party interference; and
- provide measurable outcomes and accountability.

For any reform based on managed competition, capitated payments, or bundling of services, any qualified organization, including home health providers, must be allowed to freely compete for contracts to serve as the managed care provider. A qualification for selection should be a track record of providing quality care in the service area.

Home health agencies have a very successful record of providing cost-effective coordination of health care services and other resources -- and are closer to the community and people served than most other providers.

Mr. KLECZKA. Thank you very much, Mr. Pyles.

Our last witness on this panel will be Carol Raphael, the chief executive officer of the Visiting Nurse Service of New York.

**STATEMENT OF CAROL RAPHAEL, CHIEF EXECUTIVE OFFICER, VISITING NURSE SERVICE OF NEW YORK**

Ms. RAPHAEL. Thank you, Mr. Chairman and members of the subcommittee.

I am Carol Raphael, the CEO of the Visiting Nurse Service of New York, and I appreciate the opportunity to be before you today and to discuss the importance of including home health care and hospice in any standard benefits package that is developed as part of health care reform.

The Visiting Nurse Service of New York is the Nation's largest nonprofit home health agency. 1993 marks our 100th year of service. Last year, we provided over 4 million visits to thousands and thousands of people in New York.

I want to make two key points today. The first is that it is essential that home care and hospice be included in any minimum benefits package, and, second, home care and hospice can be a vital part of the solution to soaring health care costs and issues of access in the Nation today.

First of all, it is important that we don't go backwards and that we don't take away the benefits that the majority of Americans have today. As Mr. Pyles pointed out, home care is a basic benefit that the vast majority of Americans have today, whether they are covered by private insurance plans, HMO's, Medicare or Medicaid.

I think that whether a person has an automobile accident, a stroke, a cardiac bypass operation, he wants to leave the hospital quickly. Home care enables them to do that. Many people receive home care for just a few days and then they are able to recover, go back to work and resume normal functioning. Home care also allows children with respiratory impairments to leave the hospital and not have to go to emergency rooms. It allows many AIDS patients to function in their communities.

It is an important part of the solution to reducing costs, because, in general, home care saves dollars. Many studies have looked at what it costs to provide things like chemotherapy in a hospital versus providing it at home. The savings are \$7,000 per month, according to a recent study.

For us, we have a program where we now serve 1,250 AIDS patients every day in new York City, and one of the programs that we have with Empire Blue Cross-Blue Shield where we are managing the care of AIDS patients. An evaluation has shown that this At Home Options Program has saved over \$5,000 in hospital costs per patient.

Secondly, home care is a bargain. On average, our visit cost is \$62. For that \$62, we treat the whole patient, not the illness, and we do a lot of preventive care and teaching.

Another example is an asthma case management program. I know a person from a previous panel described the problems that asthma presents to children. Asthma is a major cause for hospitalization for children in New York City. We recently started a home and community-based asthma program, and in one hospital

no child in the program with asthma has visited an emergency room since we started this program.

I think that everyone recognizes that all of us and most Americans prefer being cared for at home. They want to retain their independence and autonomy, and we believe patients heal and recover more quickly and comfortably at home.

A very important reason why home care can be part of the solution to the problems the Nation faces is because it is a flexible system. We were called 2 years ago to do mass immunizations for a measles epidemic that had struck in New York City. Within a short time, we were able to set up a system where we were able to immunize hundreds of children very, very rapidly, and it didn't cost a lot of money, because home care is not capital intensive and doesn't involve bricks and mortar.

We recently established a substance abuse treatment program in Central Harlem, a prenatal care program in an underserved area of Queens, and we have an array of community-based mental health programs serving 2,200 individuals, many of whom are severely mentally impaired.

So I point out to you that if you need to implement quick screening programs for tuberculosis or quick vaccination programs for children, home care is a very, very viable and important way to get that done.

The last point that I want to make is that any inclusion of home care should recognize the important role that community health nurses can play in preventive and primary care, and they can do this at often lower cost and with equal quality. It is important to recognize that nurses have repeatedly practiced in places like rural areas and inner-cities where there is insufficient health care, and they can deal with some of the issues of the shortage of primary care practitioners that we are trying to grapple with today.

I would like to thank you for a chance to address the subcommittee. I appreciate the opportunity to share my thinking with you.

Thank you.

[The prepared statement follows:]



**TESTIMONY OF CAROL RAPHAEL**  
**Visiting Nurse Service of New York**

Mr. Chairman and Members of the Subcommittee, I am Carol Raphael, Chief Executive Officer of the Visiting Nurse Service New York. I appreciate the opportunity to appear before you today in order to discuss the importance of including home health care and hospice in any standard benefits package that is developed as part of health care reform.

Celebrating its 100th year of service this year, the Visiting Nurse Service of New York -- VNS for short -- has an unwavering commitment to meet the health care needs of individuals who traditionally lack access to health care services, such as the frail elderly, AIDS patients, and the inner-city poor. We are very pleased that serious efforts are now underway to reform the health care system and urge that universal access to health care services be a central component of any reform plan.

As the nation's largest non-profit home health agency, VNS made almost 1.5 million professional visits and furnished over 11 million hours of paraprofessional service to more than 70,000 patients in 1992. Serving an extraordinarily diverse patient population in New York City, VNS has substantial experience in successfully developing and implementing a wide array of home care programs to meet both people's short-term acute and long-term chronic care needs. Our long experience demonstrates that home health care is cost-effective in treating a wide range of illnesses and health problems. Moreover, VNS's experience vividly illustrates that home health care is infinitely flexible in its ability to adapt to the changing needs of diverse patient populations and is an efficient way to deliver preventive services and primary care. It also can respond quickly to new technology and changes in clinical practice to meet patient needs which previously required institutional care.

**HOME HEALTH CARE AND HOSPICE SHOULD BE INCLUDED  
IN ANY STANDARD BENEFITS PACKAGE**

VNS urges that any standard benefits package include a home health care benefit and a hospice benefit. At a minimum, the package should include the current home health benefit and hospice benefit as included in Medicare.

Home health care. The Medicare home health benefit is an acute care benefit with relatively stringent eligibility criteria. Recognizing its limitations, VNS nevertheless believes that the scope of the Medicare benefit represents a reasonable beginning for home health coverage in a standard benefits package.

Hospice Care. The Medicare hospice benefit, as currently structured, includes a comprehensive set of health and supportive services to meet the palliative care needs of terminally ill individuals who select this care approach. Using an interdisciplinary team and extensive case management, hospice is a humane and cost-effective mode of care. Also, Medicare's prospective payment system for hospice effectively controls the program's expenditures for hospice care.

Primary care and preventive services. VNS also supports the inclusion of primary care and preventive services in any standard benefits package. Home health nurses not only provide and coordinate services, but play a key role in health care teaching and monitoring patients' needs for preventive services and primary care interventions. To the extent that preventive and primary care services are included in a standard benefits package, home care should play a key role in providing these services.



**COVERAGE OF HOME HEALTH AND HOSPICE  
IS ALREADY WIDELY AVAILABLE**

In addition to its inclusion as a covered Medicare benefit, Medicaid has required states to include home care services since 1970, and Federal requirements for HMOs have mandated the provision of home health care since 1973. Medicare added hospice as a covered benefit in 1982. Hospice was made an optional benefit under Medicaid in 1986, and in 1992, thirty-five states included hospice as a Medicaid-covered benefit.

Both home health care and hospice care also are already covered under most private health insurance plans as a standard benefit.

- The Blue Cross and Blue Shield Association reports that 90% of Blue Cross/Blue Shield plans in 1990 included a home health care benefit.
- The Health Insurance Association of America ("HIAA") found that in 1990, home care coverage existed for 83% of insured employees in conventional health plans and for 86% - 89% in HMOs and PPOs.
- 75% of insured employees of medium and large employers had home health coverage in 1990, and the Bureau of Labor Statistics found that 79% of insured employees in small businesses had such coverage.
- According to the HIAA, more than 80% of employees in medium and large companies have hospice care as a covered benefit.

We recently polled some of the leading health insurers to determine the scope of home care services covered in their health care policies. The attached "Schedule of Home Health Care Coverage" contains a summary of these benefits and indicates that, on average, 200 home care visits per year are covered.

**HOME HEALTH CARE IS COST-EFFECTIVE**

In New York City, a high cost health care market, VNS provides quality service at a reasonable cost. Our overall average cost per visit, based on more than 4 million home visits to more than 70,000 patients with every known diagnosis, is approximately \$63.00.

Moreover, we can demonstrate that a number of our specialized programs are substituting successfully for more expensive inpatient hospital care or other types of institutionalization. For example:

- VNS's Pediatric Asthma Program enables children and their families to manage their asthma more successfully, resulting in fewer hospitalizations, fewer emergency room visits, fewer days lost from school and work, and an improved quality of life for the patient and family.
- Through its At-Home Options Program ("AHOP"), a Blue Cross capitated managed care program for AIDS patients, VNS has successfully used home care to reduce hospitalizations for this high risk group of patients. A preliminary study indicates that those participating in AHOP incurred \$5,068 less for inpatient admissions and

\$720 less in outpatient institutional claims than those who did not participate.

- With respect to long-term care, VNS's Nursing Home Without Walls Program, a home-based alternative to institutionalization, provides an array of health and supportive services to frail and functionally dependent elderly at 75% of the cost of nursing facility care.

Several studies also highlight the cost-effectiveness of home health care. For example:

- Studies by Aetna Life & Casualty Company show an impressive savings of \$78,000 per case for victims of catastrophic accidents compared with hospital care, and an astounding \$200,000 per case savings by treating technology-dependent children in their homes compared to the hospital.
- U.S. News & World Report reported in 1988 that chemotherapy provided at home saved \$7,000 per month compared to hospital care (\$3,500 per month at home; \$10,500 per month in hospital) and that spinal cord injuries treated at home saved \$9,900 per month compared to hospital care (\$13,900 per month at home; \$23,800 per month in hospital).
- According to Blue Cross, which has at least a dozen plans now offering programs to encourage early maternity discharges to home care, there would be an estimated \$40-\$50 million annual savings in hospital costs if only one-half day were cut from the average 3-day normal delivery stay.

Finally, in discussions with several insurers, we have learned that the relative cost of the home care component of health insurance is negligible. For example, Empire Blue Cross Blue Shield informs us that home care accounts for 0.5% of the cost of its base premium for a policy. The John Hancock Company stated that the cost of home care is so minimal that it is not even considered when the company underwrites a group's coverage.

#### AMERICANS PREFER HOME HEALTH CARE

Home health care is the choice of consumers and is a preferred alternative to hospitalization or institutionalization. It is humane, maximizing independence and dignity for those requiring services. Home care emphasizes community and family support, coordinates health and social services, teaches people to care for themselves, and thus enables patients to maintain their independence in a non-institutional setting. Home care keeps our parents and grandparents out of nursing homes, encourages good nutrition among pregnant women and frail AIDS patients, and brings our at-risk babies home from the hospital. It enables families to care for chronically ill children in the home, and allows disabled family members and neighbors to remain independent and in their communities.

Furthermore, home health care is preferred because it permits earlier discharge from the hospital, or eliminates hospitalization altogether, and facilitates an earlier return to work and a productive life. Studies show that individuals recover more quickly and their potential is maximized at home, whether they are being treated for an acute, chronic, or even a catastrophic illness.

# HOME CARE IS A RESPONSIVE AND FLEXIBLE MEANS OF PROVIDING SERVICE

Home care is a responsive and flexible means of providing service. As new, portable technology transforms the health care industry, home health care is playing an expanding role in providing high-quality care to patients with increasing levels of acuity. In the last ten years, technological developments have enabled home care to provide the following services to patients in their homes -- services formerly available only in higher cost hospital settings:

- Chemotherapy
- IV-Antibiotic therapy
- Parenteral and enteral nutrition therapy
- Respiratory therapy
- Care for premature and low birth weight babies
- High-risk pregnancy monitoring
- Head and spinal cord injury care
- Hospice care for the terminally ill

Furthermore, VNS serves a culturally, ethnically, and economically diverse population of all ages in New York City. Due to the flexibility of home care, VNS is able to meet these diverse needs through innovative programming. For example:

- Begun in 1986, VNS now has a program to serve almost 1,200 AIDS patients a day, more than any hospital in New York City, and fully 10% of the city's AIDS caseload.
- Fitting the program to the patient, not the patient to the program, VNS has piloted the "First Steps Program" for substance-abusing mothers and their children in Harlem and the "Instep Program," in which we coordinate an array of prenatal care for pregnant teenagers in the Rockaways, an underserved area in the borough of Queens.
- VNS currently is developing, under a HCFA grant, an innovative Community Nurse Organization ("CNO") model which will provide primary care, certain home health services, and durable medical equipment to enrollees on a capitated prepaid basis.
- VNS also has demonstrated that the home care delivery system can be an efficient and cost-effective provider of preventive and primary care services through its ambitious child immunization programs in the New York City school system, most recently to deal with the measles epidemic.

Finally, I wanted to mention VNS's Community Mental Health Programs, which now serve 2,200 individuals. Our agency provides an array of home and community-based programs designed to reach individuals and families whose mental health needs may otherwise "fall through the cracks" of the complex and often fragmented service delivery system. Program participants include mentally impaired children, homeless individuals and families, AIDS victims, the elderly, as well as the seriously and persistently mentally ill and MICA (mentally ill chemical abusers) group. Integral to the philosophy of a large home health agency is our long tradition of bringing mental health services to the patient. A schedule containing brief descriptions of our innovative mental health programs is attached to this testimony.

### HOME HEALTH AGENCIES ARE ALSO MANAGERS OF CARE

In any health care reform proposal, qualified organizations, including home health providers, should be allowed to freely compete to serve as the managed care provider, so long as the provider has a proven track record of rendering quality care.

Home health agencies have long been successful as cost-effective coordinators and managers of health care and social support services, since they are closer to the community and people they serve than are most other providers. In fact, Medicare and Medicaid mandate that home health agencies provide assessment and case management of their patients. Under current New York State regulations, VNS coordinates a full array of services to patients in the home including nursing, therapies, paraprofessional services and social work, and is responsible for working with patients' family members, the physician and the community to ensure safe and effective health care at home. We are involved with overseeing all the patient's needs, from the time we make an initial assessment at the time of admission, throughout the patient's stay with us, and beyond.

### CONCLUSION

To be effective, health care reform must focus not just on how health care is paid for, but how it is provided. The construction of the standard benefits package will play an important part in determining where and how care is provided. Home health care and hospice, which are provided in the community, not in institutions, offer the nation an opportunity to receive health care services that are both humane and cost-effective.

Again, I appreciate the opportunity to share the views of the Visiting Nurse Service of New York with you, and I would be pleased to answer your questions.



SCHEDULE OF HOME HEALTH CARE COVERAGEEMPIRE BLUE CROSS & BLUE SHIELD

Visits allowed: 200 visits per year.

Disciplines covered: Registered Nurse (RN), Physical Therapist (PT), Speech Therapist (ST), Occupational Therapist (OT), Home Health Aide (HHA - each visit up to four hours), Supplies, Equipment.

Coverage: 100%

Deductible: No deductible.

Out of pocket expenses: None.

Does accept assignment of Benefit.

Prior Hospitalization required; patient must be seen within 7 days of discharge or benefits are reduced.

Billing documentation needed: Doctor's orders  
RN Notes  
Plan of treatment.

HEALTH INSURANCE PLAN (HIP) HMO

Covers visits by a Certified Home Health Care Agency. HIP physician must prepare the skilled home care plan in writing for the treatment of an illness or injury. Provides all home health care benefits specified in contract as HIP physician determines necessary and appropriate.

Nursing care under the supervision of a registered nurse.

Short term physical, occupational or speech therapy.

Medical supplies, drugs or medications.

Diagnostic tests and laboratory services.

There is no limitation to the number of visits duration of a visit, but limits HHA service to 35 hours per week.

AETNA COMPANY

Visits allowed: Subject to Group (generally between 100 and 365 visits per year)

Disciplines covered: RN, PT, ST, OT, HHA, Supplies, Equipment.

Coverage: Between 80% and 100%

Deductible: Amount depending on Group.

Out of pocket expenses: Amount depending on Group.

Does accept assignment of Benefit.

Hospitalization: Required depending on Group.

Billing documentation needed: Doctor's orders  
RN Notes  
Plan of treatment.

EQUITABLE

Visits allowed: Subject to Group (generally between 100 and 365 visits per year.)

Disciplines covered: RN, PT, ST, OT, HHA, Supplies, Equipment.

Coverage: Between 80% and 100%

Deductible: Amount depending on Group.

Out of pocket expenses: Amount depending on Group.

Does accept assignment of Benefit.

Prior Hospitalization required depending on Group; patients must be seen within 7 days of discharge or benefits are reduced.

Billing documentation needed: Doctor's orders  
RN Notes  
Plan of treatment.

TRAVELLERS

Visit allowed: Subject to Group (generally between 100 and 365 visits per year.)

Disciplines covered: RN, PT, ST, OT, HHA, Supplies, Equipment.

Coverage: Between 80% and 100%

Amount of Deductible/out-of-pocket expenses depends on Group.

Does accept assignment of Benefits.

Prior Hospitalization required depending on Group.

Billing documentation needed: Doctor's orders  
RN Notes  
Plan of treatment.

METROPOLITAN

Usual Visits allowed: 200 VISITS

Disciplines covered: RN, PT, ST, OT, HHA, Supplies, Ancillaries, Equipment.

Coverage: Between 80% and 100%

Amount of Deductible/out-of-pocket expenses depends on policy.

No Prior Hospitalization required.

Billing documentation needed: Doctor's orders  
RN Notes  
Plan of treatment.

**COMMUNITY MENTAL HEALTH PROGRAMS  
OF VISITING NURSE SERVICE OF NEW YORK**

**MOBILE CRISIS MANAGEMENT PROGRAM** responds to people who are experiencing extreme emotional stress, working to prevent emergencies before they happen. Services include outreach, in-home assessment, diagnosis, short-term treatment, and linkage to community-based agencies. These services provide a bridge for resistant or isolated patients to the community-based service delivery network. Program staff help to facilitate both voluntary and involuntary hospitalization, when appropriate.

**IN-HOME GERIATRIC MENTAL HEALTH PROGRAM** provides a trained team of experts, including psychiatrists, nurses, and social workers who offer individualized consultation, evaluation, long-term treatment and case management to elderly, mentally-impaired persons in their homes. This program, targeted to isolated elderly patients, enables us to reach a population who lack important health care and who would otherwise not receive mental health services.

**INTENSIVE CASE MANAGEMENT PROGRAM** coordinates treatment and planning, provides linkage to community resources, and advocates for clients who are severely and persistently mentally ill. Participants include frequent users of psychiatric emergency rooms; extended care state psychiatric patients; and mentally ill people who are homeless. This long-term service engages those clients who are among the most difficult to reach.

**HOME-BASED CRISIS INTERVENTION PROGRAM** provides in-home mental health intervention for seriously emotionally-disturbed children and adolescents and their families. The program has made a strong impact in preventing psychiatric hospitalization and preserving the family unit at a time of psychiatric crisis. Within 24 hours of the referral, a crisis intervention team member enters the home, assesses the situation, and works intensively with the entire family to diminish the crisis. The counselor then helps the family to develop various support networks and develop the skills needed to resolve their problems.

**FAMILY SUPPORT SERVICES - RESPITE CARE PROGRAM** provides a supportive and refreshing break to families of children with serious emotional disturbances, through the provision of personal care in the home; brief supervision of children; structured recreational activities; and assistance with development of parenting skills and behavior management techniques. The program builds on the strengths of families and offers concrete support to caregivers to avoid burnout that may precipitate neglect, major family disruptions or out-of-home placement.

**AIDS MENTAL HEALTH PROGRAM** addresses the AIDS client's underlying or concurrent psychiatric disorder and/or behavioral problems through home-based intervention and support. Program staff complete a comprehensive psychological and neurological assessment, followed by individual, couples or family counseling to help both the patient and his/her caregivers. The program is a collaborative effort between VNS' community mental health, and its physical health care programs, which serves over 1,200 AIDS patients daily. The program also includes a research component designed to investigate the prevalence of mental health issues among homebound AIDS patients.

**CASE MANAGEMENT FOR FAMILIES AT RISK OF HOMELESSNESS**

Two distinct programs in the South Bronx provide short-term case management to families with longstanding issues that could lead to homelessness. One service is targeted to families who have recently moved to permanent housing from a shelter to assist them in adjusting to their new home and community. Our other case management program is directed to families who are at risk for eviction, due to problematic behaviors.

Mr. KLECZKA. Thank you, Ms. Raphael.

Let me recheck one of the figures you indicated to us in the testimony. When you were talking about the home visits for AIDS patients, you indicated that, through the Empires Blues, you had saved \$5,000 in hospital costs?

Ms. RAPHAEL. Yes.

Mr. KLECZKA. \$5,000 per person?

Ms. RAPHAEL. Per person.

Mr. KLECZKA. Thank you.

Let me turn to my colleague, Congressman McNulty, please.

Mr. McNULTY. Thank you very much, Mr. Chairman.

I join the Chairman in thanking all of the panel members for their testimony. I know all of you could have said a lot more, but, unfortunately, so many people want to testify on this subject, that our lives are controlled by that little set of lights down there.

Dr. Cornell, you were doing a pretty good job of speed reading, but by the time the red light had come on, you had only gotten about half-way through your testimony. But you did make the point at the end about medical education, which you and I have discussed before. I would like to ask you to elaborate on that, at least for a moment, for the record.

Dr. CORNELL. Thank you.

Medical education is really a national responsibility and it should be added into any particular payment that the teaching hospitals get. We support changes in medical education, certainly, the weighting and the things that are necessary to change the mix of students and residents into more primary care, no question about that, and that should be done through a national commission. I don't think we have any problem with that.

But I would strongly advocate that medical education is a national resource and it is also a national responsibility and it should be part and parcel of any particular payment for services that hospitals receive, whether it is from the Federal Government or whether it from the State governments or whether it is from any other insurer. So I am strongly advocating, yes, changes in medical education are necessary, no question, but it is a national resources and a national responsibility.

Mr. McNULTY. Thank you, David.

Thank you, Mr. Chairman.

Mr. KLECZKA. Dr. Cornell, let's further expand on the medical education part of your testimony. You indicate in your testimony that we need a change of the mix, and I think everyone recognizes we need more primary care physicians. How do we, through the reimbursement policy, try to direct or redirect students or residents into that type of a practice? Let me start with Dr. Cornell, and any other panelists who care to respond also is welcome to do so.

Dr. CORNELL. I think it goes well beyond just the reimbursement system. Obviously, the things that are going on with different weights, with different payments for direct medical education and indirect to foster more primary care students is one way.

I think you have to do other things other than the reimbursement system. Many physicians coming out today have tremendous debt and there needs to be something done along either reducing



that debt or waiving away from the debt, if, in fact, you want someone really to go into primary care.

Reimbursement is going to be an issue of the physician. We are heavily procedure based, heavily technically specialty based, in terms of our reimbursement. I think that whole particular system has to be looked at in terms of how we want to reimburse physicians, especially if we are trying to lure them into primary care. When you have \$100,000 or \$120,000 of debt, you are going to make \$80,000 a year, it is no secret that the mathematics of what it takes to pay that back. If you are going to make \$1.5 million or whatever as some specialty might do, it is easier to pay it back. So we have got to do that.

I think we also have to encourage the medical centers doing education. Whether it is grants, as we have in New York, for a curriculum change, we are going through a massive curriculum change at Albany Medical College to do a different job in how you train physicians with good role models and going to the psychosocial behavioral model, if you will, so you see patients on the first day, not on the third year. And by having good role models and getting physicians more interested in the patient early, we think we can make a change in how we can influence people to be in primary care.

So I think it is more than just the reimbursement system of hospitals. I think you have to take a look at the total package.

Mr. KLECZKA. Would anyone else like to respond?

Mr. ZITNAY. I would like to comment on that.

Mr. KLECZKA. Dr. Zitnay.

Mr. ZITNAY. In a different capacity, I serve as the chair of a newly established National Center for Medical Rehabilitation Research at NIH. Congress just established that center 2 years ago. As a result of that, I also serve on the council of the National Institute of Child Health and Human Development.

One of the things I would like to say about primary care in terms of physician education is that, quite frankly, if you take a look at the amount of fellowships that are available in that area, it is abysmally low. If you are in a different specialty or different area, there are many more fellowships, many more opportunities available. Quite frankly, one of the incentives I would suggest would be to look at other ways to encourage people to go into primary care.

Mr. KLECZKA. Dr. Reinstein.

Dr. REINSTEIN. I will make a couple of comments. It is interesting, because 20 years ago, when I went into physical medicine and rehabilitation, we had 500 residency slots and only half of them were filled and only half of the ones that were filled were filled with American graduates, and we were kind of where primary care is today. Nobody wanted to do this.

If you fast-forward 20 years later, we have 1,100 residency positions and 1,000, of them are filled and 98 percent are American graduates. So the question is what happened in these 20 years. What is interesting is they talk about the solution is there should be more programs in medical schools.

We are only in half the medical schools in the country, but people discovered us and, frankly, what happened is that what attracted the medical students to our field were lifestyle and economics, and that is the bottom line.

Now, one of the goals of the RBRVS was to redistribute the wealth, take from the rich and give to the poor. That hasn't quite happened yet, and unless people are serious about it, it is not going to happen. The concept of paying a hospital 1.1 for a primary care resident and .9 for a specialty resident isn't going to work, because what you are saying to that resident is we will give you \$1,500 a year more for 3 years, and then for the next 40 years of practice you earn half of what the specialist earns. Most medical students are probably not going to buy that kind of a deal.

I think what has to happen is you have got to literally redistribute the wealth under RBRVS, and the other thing is you have got to get the medical schools to say, OK, we have got 100 people in this class and we are going to reserve 50 slots in this medical school class for people who want to go into primary care. Because once they are in the medical school, once they are exposed to the high-tech, the role models, the lucrative practices of the specialists, they are not going to then go into primary care.

Mr. KLECZKA. Thank you very much.

Mr. Pyles, you have already answered the question and it is one that the Chairman is quite interested in, as well as other members of the committee, and that is who should design the actual basic package. Should it be some type of hybrid commission, or should you leave it to us poor old members of Congress who in the long run will have to pay for whatever recommendations we make or the hybrid commission makes?

We will start off with Dr. Reinstein.

Dr. REINSTEIN. I will go with Congress.

Mr. KLECZKA. Things are looking up for physical medicine already.

Dr. REINSTEIN. Our organization hasn't taken a position, but let me give you my own personal opinion. I would agree, first of all, with Chairman Stark who said about managed competition, and I will quote: "Managed competition is to health care what the Laffer curve was to economics, a hope and a prayer and an untested theory."

I have been out to Jackson Hole. It is very nice. I think the air is kind of thin up there and maybe they are not getting enough oxygen up to the brain. The other issue with it is that it is so far removed from the real world, and I think that is one of the problems.

I think Congress has to tackle this problem. I think the best hope we have for health care reform is to create some kind of a regulated utility system. We have a gas and electric company in town. The CEO does pretty well, but he didn't make the cover of Business Week.

Mr. KLECZKA. Who is the gentleman on the cover that you mentioned before?

Dr. REINSTEIN. Thomas First, and he is the CEO of Hospital Corporation of America.

Anyway, we have none of the 10 people on this list that run any of the major public utilities. I think if we view health care as a right, then we have to establish it as a regulated utility. I think that the people who work in it deserve a fair income, but not an outrageous income. I think the investors in it deserve a fair return on investment, but not an outrageous return on investment. I think



that is our best hope for health care reform, and I think it is best done through the Congress.

Mr. KLECZKA. Thank you.

Dr. Zitnay.

Mr. ZITNAY. I would like to suggest that his example about utilities, Congress does not run the utilities. They regulate the utilities. Congress does not run the Army or the Navy or the Marines. They do that through the Joint Chiefs of Staff.

My point is I think that we should have faith in the people and I think the faith in the people can be those individuals who can be appointed and regulated with oversight by Congress. I would suggest some type of a national panel with consumers involved.

Mr. KLECZKA. Dr. Cornell.

Dr. CORNELL. I would agree with that. Interestingly enough, about 25 years ago, I believe Ann Somers of Princeton wrote a very interesting book on health care as a public utility or the model of health care as a public utility. It might be worth finding and digging out. It never caught on in 1968-70.

Mr. KLECZKA. Thank you.

Dr. MOFFAT. The American Physical Therapy Association has taken the stance at this time that they would prefer to see health care regulated as public policy and, therefore, those officials who are elected public policy officials be the ones that are responsible for attainment and putting forth of the appropriate guidelines for health care.

I would just like to add one other thing, in talking about the inadequate numbers of primary care providers. I would hope that Congress would continue to look at other individuals who can serve as gateways to the system. We have traditionally had a system where medicine has served as the gatekeeper, and I think there are alternate providers who are trained competently to render a skill that can also serve as gateways into the system.

Mr. KLECZKA. What do you call them, gate waiters?

Dr. MOFFAT. Possibly, gateways into the system.

Mr. KLECZKA. Who is the gatekeeper.

Dr. MOFFAT. Right. Traditionally, medicine has been the gatekeeper in the system and I think you have nurse practitioners, you have nurses, you have physical therapists, occupational therapists, and you have many others who have skills who are capable of serving as gateways into the system.

Mr. KLECZKA. Let's continue with the question on who should actually formulate the basic package.

Ms. CUSHMAN. The National Association for Home Care feels very strongly that any definition of benefit package should be clearly articulated before legislation is passed from Congress on health care reform.

Mr. KLECZKA. We agree with that, but articulate it. Should a national board, or should the Congress themselves formulate the basic package, and who is covered by it?

Ms. CUSHMAN. Potentially, a combination of both. There is a great deal of information being gathered by the administration now in hearings, a lot of knowledgeable people involved. There are many individuals very knowledgeable in Congress about benefits,

and Congress has successfully put together several health care packages with a history of success.

Mr. KLECZKA. Thank you. Ms. Evert.

Ms. EVERT. Yes, Mr. Chairman, having been a politician in California over a hospital system, I am very aware that politics is very much a part of health care. I personally feel that the accountability factor is very, very important. Our association does not have a stand on this, but I would echo what Ms. Cushman has said here, that I think the accountability can be done very, very nicely through the Congress and through the experts that you have available.

Mr. KLECZKA. Thank you.

Ms. RAPHAEL. I would suggest that the Congress set the original minimum benefit standards, because I think the decisions are not only on what is cost-effective and where do the outcomes justify some service being included, but I think there are really very serious economic and political issues that have to be weighed and tradeoffs have to be made.

From that point forward, I think there is value in setting up a national health board to then modify the original package and possibly add new services or protocols and determine whether or not they have efficacy.

Mr. KLECZKA. Thank you. Mr. Pyles.

Mr. PYLES. If I could elaborate on my statement a little bit, this is something we feel very strongly about. I agree with Ms. Raphael that certainly Congress could seek input from a board, perhaps. But the decisions concerning what goes into a basic benefits package are literally going to be life and death decisions for citizens of this country and for the businesses, the health businesses of this country.

These decisions could not be more important. I feel they really must be made by the elected representatives of this country who are accountable to the consumers and to the taxpayers for the decisions about what goes into that package. These are tough decisions, extremely tough decisions, but that is what our representatives were elected to do—make those decisions.

Mr. KLECZKA. Thank you.

Let me thank the entire panel for their testimony today. We appreciate your patience. Again, your entire statements will be made a part of the committee's permanent record.

Thank you very much.

[The following was subsequently submitted by Chairman Stark:]

I would like to note for the record the importance of rehabilitation and effective treatment of those who have suffered a disabling accident or illnesses. I have just received a copy of the following letter addressed to Mrs. Hillary Rodham Clinton from one of my constituents. It is one of the most moving, extraordinary letters I've ever received. The writer is obviously a person of great patience, love, and quiet heroism—as is her husband.

I would note that the letter is dated March 23, 1993. Mrs. Johnson's husband died on April 12, 1993.

[The letter follows:]



March 23, 1993

MAR 23 1993

Ms. Hillary Rodham Clinton,  
Attorney at Law  
c/o The White House  
1600 Pennsylvania Avenue, N. W.  
Washington, D.C. 20500

Dear Ms. Clinton:

I am writing you to request that in your research regarding a new medical program for our Country's citizens, you spend some time considering a subject very close to my heart -- i.e., the "custodial" patient.

I am the proud wife of a "custodial patient" who is custodial as to his movements only. He suffered a stroke ten days after we were married in August of 1970 (an aneurysm at the base of his skull). He was 40 years old at the time. He had suffered from high blood pressure for many years -- identified when he was 18 years old.

He completely recovered from that stroke, amazing his doctors at Stanford University Hospital, and was able to return to work after several months.

On February 6, 1976, he had another aneurysm in the same area which left him paralyzed on the right side -- he could still speak. He was transferred to a County Hospital to enter what we were given to understand was, "the best physical therapy possible for his needs." His former employer, New York Life, paid for his board and room.

Government-run hospitals leave a lot to be desired. They drugged him in an effort to control his natural desire to maintain his independence. I was in the process of arranging his transfer to a private convalescent and rehabilitation hospital when he suffered a third massive aneurysm, leaving him entirely paralyzed except his for his mind and memory.

My husband was given the title "custodial," and every attempt I made to get him out of that "hell hole" was thwarted when the doctor in charge -- a retired orthopedic doctor -- identified him as such. The Veteran's Hospitals would not take him -- Stanford would not take him back -- our local hospital would not take him in.

Ms. Hillary Rodham Clinton,  
 Attorney at Law  
 March 23, 1993  
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We were lucky that my then 75-year-old father-in-law played tennis with a retired physical therapist who had connections with the head of the physical therapy department at a Kaiser Hospital facility in Vallejo, California. He was transferred there in December 1976. They removed the tubes from his nose which had been there for 10 months and started feeding him. Surgery was performed to insert a "G" tube into his stomach for his feedings.

My husband continued to progress -- began eating, drinking through a straw, talking in a language understandable to most people, and came home to a convalescent and rehabilitation hospital in Fremont, California (where our home is located).

The "G" tube was soon removed, and he started eating and talking, albeit not as he had done, but amazingly well.

My husband (Hal) wanted to fill his hours continuing his education. He decided he wanted to know everything there was to know about Astronomy. We bought books, checked out library books, furnished him with everything we could to fill his days. He read with the aid of a "headwand" which fit around his forehead to the back of his head, held in position by a chin strap and cup which ran from ear-to-ear.

A good friend at the convalescent hospital then re-interested him in Ham Radio. He had served in the Navy during the Korean Conflict in many areas. He knew Morse Code; he flew helicopter rescue and spent several hours in the water when his helicopter was shot down as he attempted to rescue a downed pilot. He had also done some demolition work as part of his duties.

Hal (paralyzed from the neck down) worked hard. He took Morse Code at 13 words a minute with his headwand, transcribed it, and then sent Morse Code, again at 13 words a minute) via a headwand, in order to attain an Advanced license. His call letters are KG6ZK. The hospital, where he resided for so many years, made it possible for him to take his tests in their meeting room. He has made many, many contacts all around the world.

We purchased two radios for him to use when he was at home (every Sunday and sometimes a full weekend), a Packrat modem to help him send Morse Code via computer -- and of course a computer to operate it all. Our roof was soon covered with antenna of every sort. He wanted, so badly, to participate in special "earthquake" maneuvers during the summer months, but I was unable to work it out for him due to his restrictions in movement.

Ms. Hillary Rodham Clinton,  
 Attorney at Law  
 March 23, 1993  
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He suffered several small strokes in 1991 resulting from small bloodclots breaking away from the aneurym area at the base of his neck. He can no longer speak, as a result, and his range of motion is limited -- leaving him unable to use his computer at the present time. Swallowing was also involved -- the same muscles in the throat were paralyzed. He developed pneumonia in January of 1992, continuing off and on through July of 1992. He wanted desperately to eat, and much of the food found its way to his lungs.

He picked up a particularly vicious staph infection called MRSA at the convalescent hospital where he was residing. On July 22, 1992, he was close to death when we moved him to the intensive ward of a local full-care hospital. They took excellent care of him, but when he was sufficiently recuperated, he was not welcome back to the convalescent hospital where he had resided for 17 years until he was clear of the MRSA infection.

He now resides in a very small sub-acute hospital in San Leandro, California; and I am unable to move him because, again, he is considered "custodial." He has been clear of MRSA for five months now, but no convalescent hospital that provides the good care he deserves wants him because he is "custodial" and not a candidate for rehabilitation. Even the convalescent hospital where he resided for so many years has rejected him by their silence.

Hal begs me to help him end his life -- as he did 17-1/2 years ago at the county hospital. He is, once more, treated like a piece of meat. He "speaks" with a straw directed to a special alphabet board I have derived. The majority of the nurses and aides do not speak English well, and therefore cannot read it. There is very little communication. Most of the aides are hired as cheaply as they can get -- they are not "nursing quality" and most of them very young and timid. My husband will die of boredom -- such a waste.

All of this leads to only one request of you -- that the term "custodial" be modified as it pertains to an intelligent mind trapped in a body that won't move. Certainly a "mind" is worth rehabilitating. Please help me, and help my husband and others like him, by finding another term for a "brilliant mind trapped in a body that won't move." My husband deserves a better end to his life than he now faces. "Custodial" has a terrible connotation to someone who is alert. "Brain dead" would better fit the term "custodial."

Hillary Rodham Clinton,  
 Attorney at Law  
 March 23, 1993  
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An individual who still fights to choose what he will wear each day; to determine when he needs an "enema;" longs to have his teeth brushed each day; to have a meaningful conversation with someone during the day; to demand that his curtains be drawn when he is being bathed or "put to bed;" prefers to wear "BVD's" rather than be diapered; needs to be set up everyday so that he can read with the aid of his headwand; someone who is just as "alive and vibrant in the mind" as you or I deserves some consideration if for no other reason than the fact that they try to maintain their dignity, their humanity.

Please consider this request for all of the "trapped people in the United States" who, but for the will of God, could so easily be you or I. We need a better definition for people like my husband -- "custodial" does not describe him. And, we need to provide "quality" care and hire nursing staff who know what "nursing" means in order to provide "dignity" and "human warmth" to their patients.

And, we should not be so quick to instruct Government representatives (good-intentioned welfare workers) who try to give a "caregiver" a way out. I was told to divorce my husband, to start a new life for myself 17 years ago -- I was told I still had a life to lead and my husband would just "have to adjust." We saw many, many wives and husbands do just that. I could not. People should be given aid to help their loved ones live out the rest of their lives in whatever manner possible to them -- not be encouraged to abandon them. We need to have some way to support "caregivers" without abandoning the "caretakers" in the process.

Whatever steps can be taken to make a change such as this will probably be done too late to help my husband -- but it should be looked into very carefully. People who have contributed, and could continue to contribute to their community and nation, should not be labeled and put away to mildew into insanity. Somehow, our nation should help caregivers provide "QUALITY" care for these survivors of catastrophic illnesses. We should be able to employ minds trapped in bodies that do not move to perform a service for their keep. My husband would have greeted such a challenge with exuberance.

We have been very fortunate to have my husband's former employer, New York Life, stand behind us through all of this. They completely disregarded all of their rules and continue to pay for his care. I don't know what would have happened to him if they had not. Yes I do -- he would have willed himself to death in the County Hospital 17 years ago without their assistance.



Hillary Rodham Clinton,  
 Attorney at Law  
 March 23, 1993  
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I want, in closing, to tell you how very happy I am that you head this medical opportunity. I heard, with interest, of your great fondness for Eleanor Roosevelt -- one of my idols as well. Women's intelligence and abilities have so long been undersold or disregarded. I'm sure you will take your place in history as a woman of great distinction.

I am, incidentally, approaching 60 years of age, and have been employed in the legal profession for 22 years. I am now working as a Paralegal in the City Attorney's Office in Fremont, California -- marked to lose my job in 1992 and saved by City Council discretion. It is hard to predict how I will fair this year. The State of California is looking to our City for between Five to Thirteen Million Dollars this year.

I voted for your husband -- have been a staunch Democrat all my life. I was raised well by parents who believed in freedom and equality for all races. We must bring America back to the people -- and I think your husband can do it. I am one of the silent majority who do not call or write. We're are never really seen, but we are there just the same. Please give him my best regards and let him know our prayers are with him. I have seven grandchildren, and I would love to see them well educated and thriving in the Country that I love.

Sincerely yours,  
 Original Signed By  
 ARLENE B. JOHNSON  
 ARLENE B. JOHNSON  
 4935 Hyde Park Drive  
 Fremont, CA 94538

c:\ Calif. Congressman, Fortney "Pete" Stark  
 22300 Foothill Blvd. #500  
 Hayward, CA 94541

Assemblywoman Delaine Eastin  
 39650 Liberty Street, Suite 160  
 Fremont, CA 94538

Mr. KLECZKA. We will now call our last panel. Let me welcome you to the Ways and Means Committee's Subcommittee on Health. We will start out with Mr. John Mahoney, president of the National Hospice Organization.

Mr. Mahoney.

**STATEMENT OF JOHN J. MAHONEY, PRESIDENT, NATIONAL HOSPICE ORGANIZATION**

Mr. MAHONEY. Thank you, Mr. Chairman.

I am here today on behalf of hospice programs across the country and the terminally ill people they serve at the bedside each day.

Let me begin by thanking the subcommittee for its decade of support of hospice care in the United States. This year marks the 10th anniversary of hospice care as a Medicare benefit. You have our grateful appreciation and that of hundreds of thousands of patients and families that have been served by hospices under this benefit over the past 10 years.

According to a recent Gallup Poll, almost 90 percent of the American public, if terminally ill, would prefer the type of services offered by a hospice. Those polled may not be able to identify those services as hospice care, but they are able to state they would prefer to die at home, cared for by people they know, with attention to the quality of their life and not necessarily the quantity of that life.

I would submit to the subcommittee that hospice, even as a still emerging health care provider, is making available on an increasingly wide-scale basis the opportunity for terminally ill people to choose an alternative to a system that is often fragmented, unnecessarily intrusive, inappropriately denies them control of their own health care, and robs them of the dignity they have cherished all their lives. At the same time, hospice is often a lower cost alternative.

Hospices have been able to achieve such success in a relatively short period of time, because they were among the first providers to use a comprehensive case management approach to caring for patients and families. Hospice uses an interdisciplinary team of professionals to develop and follow a patient's centered care plan. Hospice services are provided by this team primarily in a patient's home, most often with the assistance of family and friends. Hospice care, with its emphasis on pain and symptom control and patient choice, provides an acute level of care defined by the patient's need, not the patient's setting.

Currently, for most Americans, hospice care is available as a covered health benefit either through their Medicare hospice benefit, Medicaid, the Department of Veterans Affairs, or private insurance.

As I said earlier, hospice has already proven itself to be an increasingly important factor in reducing the costs of terminal care. A recent research article in the Journal of the American Medical Association reports that patients not enrolled in hospice care spent 23 of their last days in the hospital, while patients enrolled in hospice care only spent 8 days in acute care settings.

A 1992 Health Services research article on hospice costs looked at Medicare part A expenditures for hospice and nonhospice pa-

tients in 1985 and 1986. The author found that for every dollar spent on hospice care, Medicare part A saved \$1.26.

The real strength of hospice care in this country is the community's involvement. Historically, hospices have been started by community volunteers and are reflective of the communities in which they exist. The community's investment in quality health care for the dying is seen in the enormous support that hospices have enjoyed over the years, as evidenced by the over 5 million hours of services contributed each year by volunteers.

Much of the ability of hospice care to reduce health care cost is drawn from this type of community involvement. We believe that it would be tragic to create a new health care system that does not continue to value the community-based provider.

In conclusion, hospice care works because it puts patients and families first. It is an important alternative to both the high-tech impersonal approach of traditional care and the desperation of euthanasia, most recently publicized by the rash of Jack Kevorkian physician-assisted suicides.

Hospice care represents one of the real success stories in our current health care system and I respectfully urge you in your deliberations to include hospice care, as currently defined in the Medicare hospice benefit in any basic benefits package that is part of health care reform, and that you continue to value the ability of existing community-based providers to best deliver such care.

Thank you.

[The prepared statement follows:]

Testimony of  
 John J. Mahoney, President  
 National Hospice Organization  
 Before  
 The House Ways and Means  
 Subcommittee on Health

April 22, 1993

**NATIONAL HOSPICE ORGANIZATION**

On behalf of the National Hospice Organization, its members and the terminally ill patients and families those hospices care for at the bedside each day I would like to thank the Subcommittee for inviting NHO to testify today regarding the development of a health care basic benefit package.

The National Hospice Organization (NHO), headquartered in Arlington, Virginia, is the only national non-profit membership organization devoted exclusively to hospice in the United States. Since 1978, it has worked to meet the needs of the terminally ill and promote the philosophy of hospice care. I have been the CEO of NHO since October, 1984 and prior to that time I was the Executive Director of a hospice in Boulder, Colorado.

NHO's members include more than 1400 provider members (local hospices) in all 50 states and some 2000 individual professional members. Forty-six states have developed state hospice organizations, who are also members of NHO.

NHO represents the interests of the terminally ill and hospice care to Congress, government agencies, the courts, other national organizations, and the public. Among the issues it has addressed are standards criteria, patient self-determination, reimbursement, hospice's opposition to euthanasia and physician-assisted suicide, licensure, and ethical practices of hospice care.

Additionally, NHO carries out a broad range of programs for the public benefit including a referral service to link individuals with hospices in their local communities, advocacy, and various informational brochures and programs. Membership services include educational symposia, fund raising support, data collection, professional publications, development of standards, operations manuals, training curriculums, technical assistance, bulletins and monographs.

**HOSPICE HISTORICAL PROFILE**

Hospice is a philosophy and program of care for the terminally ill that is currently one of the most frequently discussed concepts of innovative approaches to health care. In 1990, the American College of Physicians presented to the National Hospice Organization the Richard & Hinda Rosenthal Foundation Award in recognition of the "recent original approach in delivery of health care or in the design of facilities for its delivery [which] will increase its clinical and economic effectiveness." However, most people are unaware that the significant recent growth of hospice care in the United States and internationally is nurtured by ancient roots.

The modern hospice can be traced to the Irish Sisters of Charity who established St. Joseph's Hospice at London in 1905. However, the hospice most often recognized as the model of contemporary hospice philosophy and care is St. Christopher's in London. Started by Dame Cicely Saunders, in 1968, St. Christopher's laid the basis for a philosophy that emphasizes palliative care, *i.e.*, pain and symptom control rather than curative care for the terminally ill.



The first United States hospice program began in New Haven, Connecticut in 1974. In the ensuing years hundreds of hospices developed across the country. In 1982, Congress passed the Medicare Hospice Benefit, expanding hospice care availability for the Medicare eligible population. This new benefit became a stabilizing force in the hospice community and announced its arrival as a credible alternative to the traditional methods and philosophy of caring for the dying.

This first attempt to make hospice care a Medicare benefit contained a "sunset clause." In 1986, this clause was removed and hospice care became a permanent Medicare benefit. Additional federal legislation has continued to expand and improve the hospice Medicare benefit. Also in 1986, states were given the option to provide hospice services under Medicaid. Today, more than 30 states provide a hospice benefit through their Medicaid programs.

Hospice, from the beginning, has recognized that death is a natural event, but an event that had been, and for many people, still is, institutionalized at exorbitant cost, with the central figure surrounded by equipment rather than family.

The history of the hospice movement highlights primarily women with vision who have recognized that people are not so much afraid to die as they are fearful of dying in pain, afraid of dying alone, afraid of being a financial and physical burden to their families, and fearful of losing the personal dignity they cherished their entire lives. Hospice responds to these fears by providing the most advanced pain control techniques available, by surrounding the patient and the family with the professional and volunteer support they need regardless of the ability to pay, and by never losing sight of the fact that the patient and family are the focus of the program of care.

### ***THE BASICS OF HOSPICE***

Hospice care is based on a philosophy which embraces six significant concepts:

- Death is a natural part of life. When death is inevitable, hospice will neither seek to hasten nor to postpone it.
- Hospice care establishes pain and symptom control as an appropriate clinical goal.
- Hospice recognizes death as both a spiritual and a physical experience. Psychological and spiritual pain are as significant as physical pain and deserve the same attention.
- Patients, their families and loved ones are the unit of care. We have learned that to effectively care for patients we cannot separate patients from their environment. That environment includes their homes, their families and their friends.
- Bereavement care is critical to supporting surviving family members and friends.
- Hospice care is made available by most hospices regardless of the patient's ability to pay.

Currently, for most Americans hospice care is available as a covered benefit either through their Medicare Hospice Benefit, Medicaid, the Department of Veterans Affairs, or private insurance. According to the Health Insurance Association of America more than 80% of employees in medium and large companies have hospice coverage. In preparing this testimony NHO learned

from one hospice in Florida that they had worked with over 400 private health plans.

Using a comprehensive case management approach, hospice care is guided by a plan of care which is developed by the interdisciplinary team in conjunction with the patient and family. The goal of the plan is to care for the patient and the family as the "unit of care," to provide an alert, pain-free life and to manage other symptoms so that individuals can "live until they die" with personal dignity and quality of life at home or in a home-like setting. Hospice professionals include:

- Nurses
- Social Workers
- Hospice Home Health Aides
- Spiritual Caregivers
- Funeral Directors
- Psychological Professionals
- Physicians
- Administrators
- Volunteers
- Bereavement Professionals
- Allied Therapists
- Pharmacists

This team of professionals works together, hand-in-hand with the patient and the patient's family, to provide efficient, effective, and appropriate care for the dying patient which enhances the quality of life for both the patient and his or her family.

In compliance with Medicare Hospice Benefit Conditions of Participation and National Hospice Organization Standards of Care this interdisciplinary team provides hospice services to the patient who has a prognosis with a limited life expectancy. These services typically include:

- Intermittent Nursing services
- Drugs, including outpatient drugs
- Physical, occupational and speech therapy
- Hospice home health aides
- Short-term inpatient care
- Continuous home nursing care during periods of medical crisis
- Physician services
- Social work services
- Spiritual, dietary and other counseling
- Volunteers
- Medical supplies and equipment
- Bereavement care for family members

These comprehensive services are available, as needed, 24 hours per day, seven days per week to the hospice patient and family.

### **HOSPICE PROFILE**

Hospice programs complete comprehensive NHO census questionnaires regarding patients and families cared for during each year. An analysis of this census information provides a statistical review which includes:<sup>1</sup>

- Current number of US hospices are estimated at over 1800, including planned and non-comprehensive programs.
- Approximately two-thirds of comprehensive hospices are Medicare certified;
- Approximately 96 percent of hospices are non-profit or government affiliated programs. Four percent are for-profit entities;
- Last year, hospices served over 210,000 patients and families.
- The average daily census of the typical hospice program is 25 patients per day. The average length of stay is 59 days;

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<sup>1</sup>Hospice Census, National Hospice Organization, Arlington, VA, 1991.

- Ninety percent of all patient care was provided for patients at home;
- Eighty-four percent of hospice patients have cancer, accounting for approximately 33 percent of all cancer deaths as reported by the American Cancer Society. People living with AIDS and those with cardiovascular disease constitute the majority of remaining hospice patients;
- Hospice programs employ over 20,000 paid professionals;
- Approximately 70,000 people, from all walks of life, volunteer with hospice programs, providing over 5 million hours of direct care and services annually.

### **THE HOSPICE SYSTEM**

Hospice care is a blending of medical models and social service systems orchestrated to provide care that minimizes unnecessary interventions and encourages and includes the presence of family members and loved ones to provide direct care and emotional comfort and support.

Currently, over 40 percent of hospice programs are independent organizations. Others are managed as departments or programs of home health agencies, hospitals, government agencies, and religious affiliates. In the Department of Veterans Affairs, some hospitals have formed their own hospice teams while others are working with hospices that already operate in their communities.

The most significant source of payment for hospice services is Medicare Part A. Additionally, the thirty-three state Medicaid plans offering hospice care are modeled on the Medicare benefit. In order to access the hospice benefit under these systems an otherwise eligible beneficiary must elect the Hospice Benefit, and waive access to other Medicare/Medicaid benefits which may be considered duplicative in nature.

Medicare and Medicaid directly pay hospices an all-inclusive, prospective daily rate based on a particular level of care delivered on that day. The four levels of care are: (1) Routine Home Care, (2) Continuous Home Care, (3) Inpatient Respite Care, and (4) General Inpatient Care. No more than 20 percent of a hospice's aggregate days may be furnished at the inpatient level of care, and there is an annual aggregate expenditure cap per hospice, calculated on a per patient basis, of \$11,551 (1992).

### **COST/BENEFIT ANALYSIS**

As is well known, 28 percent of all Medicare expenditures are for people in the last year of life, and almost 50 percent of those costs are expended in the last two months of life. The majority of these costs go towards hospitalizations and the associated costs of high-tech interventions.

A recent study published in the Journal of the American Medical Association completed at the Moffitt Cancer Center and Research Institute and University of South Florida, indicated that the majority of patients with certain cancers admitted to the intensive care unit die before discharge, or, if they survived the term of hospitalization, they spend a minimal amount of time at home before dying. This treatment is done at great cost to the health care system and the patients and families. The study noted that this financial burden may considerably affect the quality of life of the surviving family for a significant period of time even though these investments did not support significant

extensions of life.<sup>2</sup>

The same article noted that those patients not enrolled in hospice care spent 23 of their last days in the hospital while patients enrolled in hospice spent only eight days in acute care settings. The cost savings associated with hospice care is in its ability to substitute for hospital days, and when acute care is required, to provide such care without the costly high tech interventions of an intensive care unit. A February, 1992 Health Services Research article stated, "Clearly, patterns of care for terminally ill patients are amenable to considerable substitution..."<sup>3</sup> It has been a goal of NHO to make that fact more readily understood by health care professionals and the general public. A reflection of the substitution consideration can be found in the recently approved Oregon Medicaid program which lists hospice care in the "Essential" category.

The success of hospices in reducing the cost of health care to date is demonstrated in another 1992 Health Services Research article on hospice costs. In this article, Dr. David Kidder looked at Medicare Part A expenditures for terminally ill patients cared for in hospice compared to non-hospice patients in 1985 and 1986. He found that for every dollar spent on hospice care, Medicare saved \$1.26.<sup>4</sup>

Kaiser Permanente conducted a hospice cost-effectiveness study in the late 1980's focusing on non-Medicare and non-Medicaid terminally ill patients who entered hospice care. The study showed an average cost savings per hospice patient of about \$1,430 to the HMO.<sup>5</sup>

### **SPECIALIZED PROGRAMS**

Although hospice care is most often associated with caring for people with cancer, hospice programs have evolved over the years to meet the needs of the entire community. Hospices have developed specialized programs of care to serve people with AIDS, people dying from Alzheimer's disease, and terminally ill children. And, recognizing that not all people can be kept safely in their own homes, hospices have begun to develop special substitute care giver programs and to serve patients in congregate living homes, AIDS residential facilities, nursing homes and even prisons. Some examples from the hundreds of these programs include:

- The Hospice of Mission Hill (Boston, Massachusetts) provides specialized, comprehensive care for persons living with AIDS, both in the individual's home and also in an inpatient and residential care facility designed to support AIDS patients and their families.
- Hospice of Jackson (Jackson, Michigan) provides specialized care for prisoners of the Jackson Federal Prison.
- Hospice of Washington (Washington, DC) and the Hospice of Northern Virginia (Arlington, Virginia) both provide collaborative programs for AIDS

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<sup>2</sup>Schapiro, David V. "Intensive Care, Survival, and Expense of Treating Critically Ill Cancer Patients." Journal of the American Medical Association (JAMA). Vol. 269, No. 6. 1993.

<sup>3</sup>Gaumer, Gary L. & Stavins, Joanna. "Medicare Use in the last Ninety Days of Life." Health Services Research. Vol. 26, No. 6. 1992.

<sup>4</sup>Kidder, David. "The Effects of Hospice Coverage on Medicare Expenditures." Health Services Research. Vol. 27, No. 2. 1992.

<sup>5</sup>Aboll-Sayf, Frank. "Hospice Care Can Yield Savings to HMOs, Patients." Healthcare Financial Management. August, 1991.



patients in Whitman Walker AIDS residential facilities, personal residences, and also provide inpatient care for those patients without primary caregivers or who are unable to be provided appropriate care for their disease.

- Hospice of Central Florida (Orlando, Florida) provides specialized care for pediatric patients and their families.
- Hospice of Dayton (Dayton, Ohio) provides services beyond the direct hospice patient/family and works with community organizations such as Compassionate Friends, Widowed Persons Groups, Survivors of Suicide, Police Departments, and Schools.

### **COMMUNITY FOCUS**

The strength of hospice care in this country is the community's involvement. Historically, hospices have been started by community volunteers and are reflective of the communities in which they exist. The community's investment in quality health care for the dying is seen in the enormous philanthropic support that hospices have enjoyed over the years and the over 5 million hours of service contributed each year by volunteers.

Much of the ability of alternative forms of health care to reduce health care costs is drawn from this type of community involvement. We believe that it would be tragic to create a new health care system that does not continue to value the community-based provider.

### **CONCLUSION**

In the recent Robert Wood Johnson Foundation sponsored meetings, "Conversations on Health: A Dialogue with the American People" speaker after speaker talked about the need for a system that is fair and based on common sense, a system that provides an array of services in a coordinated fashion, that allows for the involvement of the family, that provides a continuum of care, and that puts as much emphasis on "low-tech" personal care as it does on high-tech interventions. In closing the meeting in Washington D.C. the Foundation's President, Steven A. Schroeder, M.D. quoted a physician he had met in a European hospital who, responding to Dr. Schroeder's observation on the lack of patients in the intensive care unit said, "The trouble with health care in America is you don't know when to stop."

During the past 15 years, Hospice has been an emerging health care provider that has already had an important impact on reducing the total health care expenditures of the country by responding to many of the issues and concerns that have been identified by the American people. Hospice care works, because it puts patients and families first.

The Subcommittee has asked NHO to speak to the question of why we believe hospice care should be included in a basic health care benefit package for the American people. I would conclude this testimony by reiterating that hospice care is a community-centered, patient/family focused, cost-effective way of humanely caring for terminally ill people when curing the patient is no longer possible. It is an important alternative to both the high-tech impersonal approach of traditional care and the desperation of euthanasia, most recently publicized by the rash of Jack Kevorkian physician-assisted suicides. When one examines the elements of what is generally considered to be important to health care reform, i.e. quality care provided in a cost-effective manner, and representative of what is already working in today's health care system, hospice care deserves consideration.

The National Hospice Organization thanks the Subcommittee for this opportunity to make our views known, and we offer our most sincere appreciation for your efforts.

Mr. KLECZKA. Thank you very much, sir.

We will now hear from the National Association of Medical Equipment Suppliers, represented by Mr. Kirson.

**STATEMENT OF DONALD M. KIRSON, IMMEDIATE PAST CHAIR AND MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, AND PRESIDENT, KIRSON MEDICAL EQUIPMENT CO., BALTIMORE, MD.**

Mr. KIRSON. Thank you.

I am pleased to testify before you today. My name is Don Kirson. I am in the home medical equipment services industry. My company, Kirson Medical, provides home medical equipment services for patients residing in Virginia, the District of Columbia, Maryland, Pennsylvania, and New Jersey.

My background and degree is in pharmacy. That, combined with my years in the home medical equipment services industry, means I have spent the last 23 years providing health care services to individuals. Currently, I am on the board of directors and am the immediate past chairman of the National Association of Medical Equipment Suppliers.

I appear before you today to discuss the important role home medical equipment suppliers play in providing health care services to many of our Nation's sick and elderly, as well as people with disabilities, and to convey to you our request that home care, in general, and home medical equipment services, specifically, be included as an enumerated benefit in any standard benefits package you develop.

I could tell you how cost-effective home medical equipment services are, but you already know that. I could tell you that 75 percent of the people surveyed prefer to be treated at home after a serious illness, or that nearly 87 percent of all HMO's offer home medical equipment services as a basic benefit, but all of that is provided in my written testimony.

What I would like to do, though, is read to you two short letters from people who have needed home medical equipment services and let you ask questions, if you wish, to Joel David Myerberg, who is a current recipient of home medical equipment services.

This first letter is from a lady who took care of her mother at home for many, many years, and I quote:

DEAR MR. KIRSON: Come June, mother will have been in her room confined to her bed for 5½ years. Many times during this period, I have called upon you and your staff. You must be concerned how I could request service so often. Every 2 hours around the clock, I turn mother. Every hour, for different reasons, the bed's position is changed, especially feeding and giving her liquid, the head must be upright. I am pleased with the new bed, especially how high her head now rises. This will ward off the possibility of her choking. For the personal care and concern you have given me, I am truly appreciative, also for Robin and Jean, for they are a bright spot each time I talk to them. Also, I would mention the two men who answered my last request, they were very polite, friendly and gentle. Without your equipment, service and kindness, I would not have been able to care for mother at home, starting my 11th year. Accept my gratitude and God's blessing upon you, yours and your life's work.

Sincerely,

KATHERINE WILHITE, Baltimore, Md.

The second short letter I would like to read involved a 15-year-old girl who was born with a birth defect, and this again is a quote:

DEAR MR. KIRSON: I want to thank you very much for the scooter and tub-lift. Your generosity has meant so much to me and my family. The use of the equipment has made my daily life so much easier. Without your help, we could not have been able to get the equipment that we needed. I have been practicing a lot and can almost go at rapid speed. My friends at school really like it, but they said there is only problem, it doesn't have a sidecar for them to ride around in. I have been to the mall and I can now spend the whole evening going back and forth and I don't get tired. The tub-lift makes bathing so much easier and more enjoyable. I am finally able to enjoy a bubble-bath again. Again, thank you for all the help that you have given us with the equipment. Thank you for being such a wonderful person.

Sincerely,

MANDY KENT, Baltimore, Md.

These are just some of the ordinary people that we help every single day. In 1989, we were fortunate enough to provide home medical equipment services for Al Gore, III, which enabled him to come home from Johns Hopkins Hospital earlier and to recuperate at home. Hopefully, it has become clear that home medical equipment knows no age boundaries, and hopefully you will understand, and hopefully I have been able to make it clear, that home medical equipment and home care needs to be part of any basic benefits package.

I thank you for your time. I will be glad to answer any questions you may have.

[The prepared statement follows:]





# NAMES

National Association of  
Medical Equipment Suppliers

**TESTIMONY  
OF  
DONALD M. KIRSON, PRESIDENT,  
KIRSON MEDICAL EQUIPMENT COMPANY,  
AND  
REPRESENTING THE  
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS  
ON  
NATIONAL HEALTH CARE REFORM  
AND  
THE STANDARD HEALTH BENEFIT PACKAGE  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
HOUSE WAYS AND MEANS COMMITTEE  
HEARING OF  
APRIL 22, 1993**

Mr. Chairman and Members of the Committee: I am pleased to testify before you today. My name is Donald Kirson. My company, Kirson Medical Equipment, serves individuals residing in Virginia, Maryland, New Jersey and the District of Columbia. I have a background in pharmacy which, when combined with my years in the home medical equipment (HME) services industry, total 23 years in providing health care services to individuals. I also currently serve on the Board of Directors and am the Immediate Past Chair of the National Association of Medical Equipment Suppliers (NAMES), the national trade association representing the HME services industry exclusively.

I appear before you today to discuss the important role which HME suppliers play in providing health care services to many of our nation's sick and elderly, as well as people with disabilities, and to convey the HME industry's request that home care in general and HME services specifically be included as enumerated benefits in any standard benefits package you develop.

Spiraling health care costs must be brought under control. Some statistics show that health care costs are the number one cause of both personal and business bankruptcies. With most businesses' health insurance premiums increasing at 20% per year, such spending by some businesses may even exceed after-tax profits. Yet, approximately 36 million Americans—nearly 16.6% of the non-elderly population—still have no health care insurance. Moreover, many of these individuals are in families which have some connection to the work force. Clearly, rising health care costs are threatening the competitiveness of many U. S. industries and reducing the ability of many people to obtain access to needed health care.

NAMES and the HME services industry applaud the Clinton Administration and Congress for tackling the difficult problem of trying to reform our nation's system of health care delivery and payment, by reducing health care spending and increasing access to needed health care services for all Americans. Most health care economists believe that only comprehensive reform can address the current myriad problems of cost and access to quality care. While the mechanics of the Clinton Administration's health care plan currently are being developed by the President's Task Force on National Health Care Reform, NAMES understands that certain key elements or themes have begun to emerge from the many major health care reform proposals under active discussion.

At present, it appears that the primary element of many national health care reform proposals encompasses some form of "managed competition." Although the precise definition for that term of art is not firm, it appears that managed competition as envisioned by the Administration and some in Congress will be based primarily on restructuring the market for health care services into competing prepaid plans, while giving various incentives to providers to offer a "standard" set of basic benefits at the lowest cost. While administration and control of a managed competition system most likely would be controlled by a separate independent entity, such as a national health board, the overall guidelines and parameters determining the scope and nature of health benefits to be offered under managed competition would be determined initially by the federal government.



As Congress works to develop health care reform legislation, cost-effective means of providing health care in the home should not be overlooked. NAMES strongly urges this Committee to consider seriously the many positive reasons to include HME services in the standard benefits package. These reasons range from the cost-savings nature of the HME benefit itself as operated currently under the federal Medicare program, to the more socially-responsive goal of providing health care services in a fashion that best meets the needs of our changing society.

NAMES understands the seemingly incompatible dilemma of reducing health care costs while also ensuring that Americans have access to a comprehensive set of health care benefits. But many health care reform experts, including the "Jackson Hole" group (as described in its "General Principles for the Development of Uniform Effective Health Benefits") believe that "covered services should be demonstrably effective, appropriate, and based on value to the individual and society."

Based upon that policy determination, the Jackson Hole paper specifically enumerates HME -- when provided via physicians' prescriptions—as one of the initial Uniform Effective Health Benefits (UEHBs). This initial set of benefits was intended by the drafters to represent neither a floor nor a ceiling of potential benefits, but rather coverage of a "reasonable" level of services based on custom and cost considerations as estimated from actuarial analysis of similar benefit plans.

The overwhelming number (almost 87%) of federally qualified HMOs in this country include HME services as a standard benefit in their health care packages. Interestingly, while "home care" *per se* is enumerated as a mandated benefit in the health care packages of federally qualified HMOs, "HME" (or the statutorily specified Part B Medicare "DME" benefit) is not mentioned separately. Nonetheless, the fact that 87% of HMOs incorporate HME services as a covered benefit reflects a clear awareness among HMOs that HME is an integral component to home care. Additionally, a well-respected coalition of individuals and diverse organizations representing people with disabilities, namely the Consortium for Citizens with Disabilities (CCD), recently released its recommendations for managed competition proposals. Specifically enumerated within the recommended comprehensive benefits package are "durable medical equipment and other assistive devices."

This philosophy is not confined to federally qualified HMOs. Most of the top twenty major private health insurance providers also currently offer HME as a basic benefit in their major medical indemnity plans. As home care services, including HME, are projected to increase in use in the coming decades, major insurance underwriters have begun to recognize the growing trends that contribute to making home care and HME viable alternatives to more costly institutional care.

There are a number of factors that have contributed to the growth in recent years of home care—and specifically HME services. Some of these reasons are relatively evident even by casual observation. Our nation's elderly population is increasing rapidly; while 31 million Americans were 65 or older in 1989, this figure is expected to more than double to 69 million by 2050. The number of older Americans will cause a continuing increase in individuals with chronic health care problems, thus increasing the demand for home care services. This is in addition to the greater number of acute care patients served by the HME services industry directly as a result of earlier institutional discharges due to the "quicker and sicker" phenomenon. As a result of this phenomenon, increasingly HME is required by patients who are discharged from hospitals while in the acute stage of illness.

The rise in home care services is not merely confined to the elderly. For example, the development of sophisticated home medical equipment has enabled parents to have their children who need life-supporting devices such as ventilators, apnea monitors or parenteral and enteral nutrition therapies remain at home for the particular care needed. Current trends evidencing higher survival rates for premature infants portend an increasing reliance on alternative health care delivery methods, such as HME, which allow infants and children to recuperate and be cared for in the home.

Many people with severe disabilities now survive accidents or injuries which would not have been possible even in the recent past. As a result, some HME suppliers called rehab technology suppliers (RTSs) have begun to specialize in the area of providing custom-designed rehabilitation equipment to individuals with severe neurological impairment, thereby allowing people who would heretofore have been confined to institutions for the remainder of their lives to lead productive lives with the assistance of rehab equipment.

Other factors, such as the expected increase in the number of individuals with the HIV virus, also will fuel the need for home care services that include HME. In general, public surveys show that many Americans recognize the potential need for home care services in the future, either for themselves or a loved one or family member. NAMES 1991 "Coming Home Survey" noted that almost 30% of Americans surveyed reported they believed it was very likely or somewhat likely that they or a family member would need such services within the next ten years.

Home care services that include HME are demonstrably more cost effective than similar care provided in a hospital or other institutional setting for certain cases. A study conducted in 1991 by Lewin/ICF compared the costs of home care versus hospital care for three distinct diagnoses (hip fracture; amyotrophic lateral sclerosis (ALS) with pneumonia, and chronic obstructive pulmonary disease (COPD)) that also utilized HME items. The study found that home care using available HME resulted in a cost savings of between \$300 and \$2,300 per patient episode. Furthermore, when

multiplied by the prevalence of each illness, the potential annual savings per year was estimated at \$575 million for hip fractures alone.

Similarly, a recent study conducted by Duke University under a National Institute of Aging grant showed that, between 1982 and 1989, there was a material increase in the number of individuals using HME services to cope with activities of daily living (ADL) deficits. Significantly, during the same period, there was a decrease in the number of individuals requiring ADL-related personal assistance. The researchers noted that, with proper recognition and incentives, HME services could reduce costs by replacing recurrent costs for personal assistance from formal sources with non-recurrent HME costs.

The HME services industry does not refute the important role of institutions for many individuals' needed medical care. Nonetheless, as advances in equipment have increased to the point where people now can safely be discharged by their physicians sooner from acute care facilities, with the knowledge that high quality services will be provided in the home by a competent HME supplier, the need to ensure that HME remains available in the future by requiring it as a covered benefit is of paramount importance.

Most importantly, as this Committee looks to include particular cost-effective health care services in a standard benefits package, NAMES encourages policymakers also to consider those intangible factors that are driven more by consumer preference than by complex and sometimes convoluted medical charts and graphs outlining various options for reform. Specifically, it is well-documented that most Americans would prefer to receive medical care, treatment and services at home if at all possible, should the need arise. A 1991 American Association of Retired Persons (AARP) study found that nearly 3 out of 4 older Americans would rather care for a disabled, frail or elderly relative or friend at home, rather than be forced to admit that person to a nursing home. The 1991 NAMES "Coming Home Survey" found similar results, in that 71% of individuals surveyed said they would rather recuperate at home, and 68% stated they would prefer home care even in the event of a terminal illness.

The HME services industry is ready to do its fair share to help reduce unnecessary Medicare expenditures that increase health care costs and the federal deficit. NAMES previously has described in some detail for this Committee our efforts to proactively take steps to help eliminate the few unethical individuals who tarnish this industry's reputation. We will continue those efforts with Congress to work toward passage of sound and responsible HME ethics legislation.

At the same time, we believe it vital that HME be specifically enumerated as a covered benefit in any health care reform bill advanced by this Committee. At the very least, any such legislation should provide specifically that home care and HME services may be substituted for hospital or other institutional care where costs would be equivalent or less.

Many people today either lack health care or are concerned about their ability to retain the insurance coverages they do have. Many individuals live with the fear that they will not be able to afford medical care if they or someone in their family become severely disabled. Along the same lines, and as the owner of a small business, I recognize the problem faced by many small businesspeople who, frustrated by rapidly escalating premiums, may have had to eliminate or scaleback coverage for their employees. Most of us can easily define health care problems as they affect us individually; solutions appear much more complex and there is relatively little consensus among experts on their precise details.

In the midst of this health care reform debate, however, some solutions do present themselves as viable options that are efficient, affordable and compassionate—namely, ensuring that HME services as a part of home care remain available for all Americans. HME suppliers meet the needs of a wide range of individuals who require medical equipment and services in their homes. We not only provide many of the more "traditional" items of equipment such as those envisioned when the Part B "DME" benefit was first adopted as part of the Medicare law in 1965, but now we also provide a vast array of highly specialized and advanced services, such as infusion therapy for the provision of antibiotics and chemotherapy, oxygen and ventilator systems, and advanced, customized rehabilitation equipment.

Home care that includes HME services should be encouraged and protected by the federal government. The alternative scenario, namely that many individuals would be forced to obtain medical care at a significantly higher cost in a hospital, nursing home or other facility, is unwise policy from both a fiscal and societal standpoint. At the same time, omitting from a health care reform bill any enumeration of specific benefits such as HME would be unwise from the standpoint of ensuring future patient access to a comprehensive set of health care services. Similarly, for the federal government to abrogate this important responsibility to another body such as a national health board would amount to shirking the responsibility owed to every American—that Congress studies all options, deliberates the merits of given reform methods and develops a responsible alternative to our country's current dilemma.

Comprehensive health care reform should establish no impediments to the use of home care currently available, or to the enhancement of care in the home and other non-institutional settings in

the future. At the conceptual level, accomplishing this goal is relatively easy; policymakers should adopt a limited number of guiding principles, as described in the following recommendations:

- Identify HME services as a required (rather than optional) basic benefit under any new health reform legislation;
- In the alternative, where home care and HME services are not included in a standard or minimum benefit plan, allow actuarially-equivalent home care and equipment to be substituted at no additional premium cost, under the standard or minimum benefit plan;
- Retain and preserve the current Medicare existing HME benefit;
- Facilitate patient access to HME services independent of institutionalization or an acute care episode, where appropriate; and
- Expedite recognition of new technology available in the home.

NAMES and HME suppliers are ready to assist Congress in any way possible, through providing more information on any of the items mentioned. I will be pleased to answer any questions you may have.



Mr. KLECZKA. Thank you, Mr. Kirson, for your testimony.

There is a vote occurring right now on the House floor, so we will take a short recess. The balance of the panel can have a 9th inning stretch or 7th inning stretch, and we will return in about 5 minutes.

[Recess.]

Mr. KLECZKA. The subcommittee will be in order.

We will now hear from Mr. Thatcher, from Kimberly Quality Care, from Boston, Mass.

**STATEMENT OF RICHARD E. THATCHER, SENIOR VICE PRESIDENT, KIMBERLY QUALITY CARE, BOSTON, MASS.**

Mr. THATCHER. Good afternoon, Mr. Chairman and members of the committee. My name is Richard Thatcher and I am a senior vice president of Kimberly Quality Care. We are the Nation's leading provider of home care services, with over 400 locations in almost 41 States.

You have heard from a number of witnesses over the past couple of days, and they have advocated I think very effectively and eloquently, for the use of home care in treating both chronic and acute conditions, so I am going to greatly condense my testimony today, so as not to repeat what they have said. You do have available, of course, the written testimony.

So I am going to focus on some of the things I think our company has done somewhat uniquely to attempt to help control the cost of health care and also provide better quality to patients, particularly in the area of applying home care to acute conditions. I will talk about three specific examples.

We have initiated these programs, in fact, over the past couple of years, long before your committee and others began their recent health care reform deliberations, because the market was demanding it of us. Managed care is a real thing out there and is a major customer for us. These programs are under way and working very effectively for us already.

At Kimberly Quality Care, we are working with a leading managed care consulting firm to design and implement a system of practice management guidelines. What this means is that for each condition, we will have available to us guidelines that integrate home care and inpatient care, by specifying appropriate lengths of stay and plans of treatment for each component of care, both the home portion and the in-hospital portion.

In essence, we will be able to manage our own utilization to produce cost-effective quality care based on predictive guidelines which we will refine and adapt over time, as we gather experience and data.

Secondly, I want to tell you about a program we have initiated and conducted with an HMO in California. As you know, California tends to be a more advanced managed care market. The medical director of this HMO enlisted us in a cooperative effort to reduce the hospitalizations that their members were experiencing.

As soon as one of their members was identified for nonemergency hospital admission, one of our nurses visited that member in his or her home. They assessed the environment, the patient's condition and the applicability of home care to that patient's plan of



treatment. Then, once the patient was hospitalized, we visited them again in the hospital to see how they were progressing and, hopefully, to facilitate an early discharge.

Once the patient was at home, we provided treatments and rehabilitation as needed to restore the patient to health. This program was extremely successful. In the 6 months following its implementation, we saved the HMO several hundred thousand dollars, in fact, almost half a million dollars, which is a very substantial sum on a membership base of less than 50,000 members. The savings estimate, by the way, is not ours, but the HMO's. This sort of cooperative relationship between an HMO and a home care agency, we believe, can represent a prototype for successful programs in the future.

A final example of effective application of home care to reduce hospitalization is in the replacement of joints, such as knees or hips. I should elaborate. We are working very hard to identify specific conditions where patients currently are staying in the hospital, frankly, longer than they need to. Knee and hip replacement is one example. Many HMO's have expressed to us their frustration over the relatively long hospital stays for these procedures, typically averaging 9 to 10 days. We have designed a program that we believe can shorten that by 4 days, approximately. Let me tell you a little about what we will do, both pre- and post-discharge.

First, we visit the prospective patient in their home, before hospitalization, before surgery, to begin rehabilitation and conditioning before the patient is weakened by the surgery. In fact, we will train them to walk on crutches before the surgery takes place. It is a very simple thing, but it can expedite discharge from the hospital later.

At this time, we also identify any needed modifications to the home, installation of a ramp, movement of a doorway, perhaps widening of a doorway, whatever it may be. Again, it can facilitate discharge from the hospital. Now, with a procedure like a hip, you can't afford too many modifications, but it is illustrative of what we might need to do.

We will visit the patient in the hospital to plan their return home, in concert with their physician and their family members. Once the patient returns home, our nurses and therapists visit them for approximately 1 week to provide the treatments they need and assist with needed physical therapy.

There is no danger to the patient through this shortening of hospital stay. In fact, as others have alluded, studies consistently find that patients are happier and recover more quickly at home. The economics are compelling. Our charges for this program will run approximately \$1,050, varying a little bit, depending on patient need and area of the country. By saving 4 hospital days, at an excess of \$1,000 a day, as I said, the economics are very compelling.

Please note that in each of these examples, home care was used proactively, prehospitalization, as a means of preparing the patient for a reduced hospital stay. We see this as an important application of home care and one that we are attempting very aggressively to expand.

By intelligently planning each patient's course of treatment, we can insure that only those treatments that must be provided in the

hospital take place in that very costly and, in fact, inconvenient setting. Care that can be provided at home should be provided at home.

I hope my remarks this afternoon have been helpful in illustrating the effectiveness of home care as one component of an integrated program to reduce spending and improve the quality and convenience of health care to many, many citizens.

Thank you very much for your time and attention. I would be pleased to respond to any questions along with the rest of the panel.

[The prepared statement follows:]

Richard E. Thatcher - Senior Vice President, Kimberly Quality Care  
 Testimony Before the Subcommittee on Health  
 House Committee on Ways and Means  
 April 22, 1993

Good morning (afternoon), Mr. Chairman and members of the Committee. My name is Richard Thatcher. I am a Senior Vice President of Kimberly Quality Care, the nation's leading provider of home care services with almost 400 community-based locations in 41 states. I want to thank you for the opportunity to share with you my perspectives regarding health care benefits.

The need to contain health care costs while simultaneously improving access to care for millions of Americans requires that we define those benefits that are necessary and cost-effective. My purpose today is to demonstrate to you that home care can and should play an important role in the package of health care benefits to be provided to all Americans -- in fact, that home care can make a significant contribution to resolving our nation's health care dilemma.

Home care has probably been thought of most often as providing assistance to the elderly, either in recuperating following hospitalization or in continuing to live independently despite chronic difficulties. These traditional applications remain valid and important, but they are only a part of the picture. Advances in medical technology are continually expanding the role of home care in treating acute conditions. It is now possible to safely and effectively treat at home many conditions that formerly required hospitalization. This not only produces meaningful cost savings, but also more satisfied patients. Numerous studies have shown that patients are happier and more comfortable at home, and that their medical progress is better.

The benefits of home care have not gone unnoticed. Home care has increasingly been recognized by managed care organizations and physicians as a cost-effective alternative to in-patient care for many conditions. Costs of providing treatment at home can be 20 to 70% less than comparable treatment in an institutional setting. For example, in one city eight weeks of hospital treatment for a child with Cystic Fibrosis and an acute respiratory infection would average about \$45,000; similar treatment provided at home by Kimberly Quality Care would average about \$14,000.

These efficiencies have been pursued by HMOs, PPOs, and insurers who have sought to move patients from in-patient to home care as rapidly as practical in light of their condition and plan of treatment. The case managers from these organizations frequently authorize home care even when not specifically included in the applicable benefits plan because of their understanding of and belief in the cost-effectiveness of home care. That is a powerful endorsement. It is understandable, as this is one of the few ways in which managed care organizations can simultaneously save money and increase patient satisfaction. Most managed care interventions must discomfort or inconvenience the patient in order to achieve cost savings. That is not the case with home care.

From a national perspective, the potential for further savings in hospital costs is confirmed by the large differences in hospital utilization in different regions of the country. Commercial HMOs in those areas with greater managed care experience have achieved hospital days per thousand in the mid 200s, while less tightly managed systems continue to run in excess of 300 days per thousand. By working closely with the HMO, the hospital, and the physician, home care can be the catalyst in enabling less efficient systems to reduce hospital expenditures while producing high quality care for their patients. This can be achieved by facilitating an early return to the home environment and rapid recuperation through an appropriate plan of care -- a plan of care that achieves the desired outcome with the minimal amount of medical interventions, both in the hospital and in the home.



At Kimberly Quality Care, we are working with a leading managed care consulting firm to develop and implement a system of practice management guidelines. For each specific condition, these guidelines will integrate home care and in-patient care by specifying appropriate lengths of stay and plans of treatment for each component of care. This will enable us to manage properly our own utilization and deliver the most high quality, cost-effective care in the country. We see such a system as a prerequisite to achieving our potential under managed competition. In fact, it will be essential to enabling us to manage our affairs appropriately in that environment, particularly under capitated contracts.

Let me provide specific examples to illustrate these concepts: one example of a broad-based managed care program, and two examples of condition specific programs.

First, the broad-based program. We began working with one HMO in California that was experiencing hospital stays that they felt were excessive. Their Medical Director enlisted us in a cooperative effort to improve their results. As soon as one of their members was identified for a non-emergency hospital admission, we visited that patient in his or her home. At that time we assessed the patient and the home environment to determine the appropriate role for home care in that patient's plan of treatment. We explained the plan to the patient and his/her physician to ensure understanding and support. We then visited the patient in the hospital to monitor their progress and facilitate discharge. Once the patient was at home, we provided treatments and rehabilitation as needed to restore the patient to health.

This program was very successful. In the six months following implementation, it saved the HMO several hundred thousand dollars, a significant savings on a membership base of less than fifty thousand people. That savings estimate, by the way, was developed not by Kimberly Quality Care but by the HMO. This sort of cooperative relationship between the HMO and home care agency represents a prototype for successful programs in the future.

More common than this broad-based program have been programs focusing on specific conditions. One condition with which most of us are familiar is the birth of a child. For many of us, our mothers were in the hospital anywhere from four to seven days. A generation later, women are more likely to be in the hospital less than three days for a normal vaginal delivery. In fact, in aggressive managed care markets, healthy mothers and their newborn children are regularly sent home in 24-36 hours. These rapid discharges are often facilitated by having a nurse visit mother and child in-home post-discharge to monitor their progress. Many programs also include visits to the home by a skilled nurse in the third trimester of pregnancy to ensure that the expectant mother is preparing and progressing appropriately.

Another example of the effective application of home care to reduce hospitalization is in the replacement of joints, such as knees or hips. Many HMOs have expressed to us frustration over what they perceive as relatively long hospital stays for these procedures, typically averaging 9-10 days. We have designed a program to shorten those stays by approximately 4 days by applying relatively simple home care procedures pre- and post-discharge:

- we will visit the prospective patient in home before surgery to begin conditioning exercises and to train them to walk on crutches; this is much easier than providing training after surgery and can accelerate the patient's return home
- at this time we also identify any needed modifications to the home and discuss the plan of treatment so the patient and any family members know what to expect
- again, we will visit the patient in the hospital to plan their return home in concert with their physician
- once the patient returns home, our nurses and therapists will visit them for one week to monitor the patient's condition and assist with needed physical therapy.

The charge for our services will be about \$1,050. This will obviously produce significant savings relative to four hospital days at \$1000 or more per day.



Please note that in each of these examples home-care was used proactively, pre-hospitalization, as a means of preparing the patient for a reduced hospital stay. We see this as an important application of home care, and one that should expand. By intelligently planning each patient's course of treatment, we can ensure that only those treatments that must be provided in hospital take place in that more costly and inconvenient setting. Care that can be delivered at home should be delivered at home.

The application of home care to continued reductions in hospital stays will result in more patients being seen in their homes for short durations, often only three to six visits. At the same time, the advent of managed competition will apply managed care techniques to the older and more chronically ill segments of our population. In current programs, such as so-called Senior HMOs, one effect has been to replace shift care with less expensive intermittent visits. We expect this trend to expand as more seniors enter managed care programs. Essentially, there will be two home care populations: a healthier group receiving short-term treatment for an acute condition to reduce or prevent hospitalization, and another group receiving longer term care for more chronic conditions. The appropriate needs of both groups must be recognized and covered.

In the more chronic situations, careful evaluation of the situation is required to determine the appropriate plan and location of treatment. Home care is often but not always the most appropriate and economical alternative. These decisions must be made through cooperative efforts involving the patient and family, the physician, the managed care organization, and the appropriate institution and home care agency. Making proper decisions is critical, as the effect on quality of life for patients and families is enormous. The design of the health care program and the benefits package must encourage such cooperative decision making in the best interests of all our citizens, particularly the chronically ill.

I do not want to conclude my remarks this morning (afternoon) without addressing concerns that home care agencies have provided excessive services to their patients for economic gain. There is no question that over-utilization has occurred, just as it has occurred throughout many areas of our health care system. Over-utilization of home care services will diminish and ultimately disappear under a health care system emphasizing managed care, such as the "Managed Competition" proposals which have been described in the media. In such a system, only the most efficient and cost-effective health plans will prosper. Home health care agencies -- in fact, all health care providers -- will need to demonstrate consistent quality, efficiency, and effectiveness.

Over time, health care services will more and more be reimbursed through fixed payment mechanisms, such as capitation. In that environment, questions of over-utilization of home care will become essentially irrelevant. Home care companies will be accountable for managing their own activity to produce the desired outcome for the patient as quickly and efficiently as possible. Failure to do so will result in direct financial loss and in declining customer satisfaction.

I hope my remarks this morning (afternoon) have helped illustrate the role of home care in providing cost-effective care and improved quality of life for so many Americans. The cost-effectiveness of home care as one component of an integrated program to reduce hospitalizations is significant. In addition, we must recognize the importance of home care in improving the quality of life for so many older, chronically ill citizens. Our need for cost savings must not fall disproportionately on that disadvantaged segment of our society.

In closing, I find it interesting to note that, in a manner of speaking, we are coming full-circle in health care. Centuries ago, health care began in the home. For many years, technological progress and economic incentives caused care to be delivered increasingly in institutional settings. Now, for many illnesses and conditions, technical advancements and economic advantages are enabling us to return health care to the home: home, where health care began, and where patient satisfaction and quality of life are greatest.

Thank you very much for your time and attention. I would be pleased to respond to any questions that you may have.

Mr. KLECZKA. Thank you, Mr. Thatcher.  
Mr. David Williams, from Invacare Corp., Cleveland, Ohio.

**STATEMENT OF DAVID T. WILLIAMS, CORPORATE DIRECTOR  
OF COMMUNICATIONS AND PUBLIC/GOVERNMENTAL RELATIONS,  
INVACARE CORP., CLEVELAND, OHIO**

Mr. WILLIAMS. Thank you.

It is a pleasure to be here today, and I want to congratulate the Chair and the members of this committee for their foresight in holding these hearings.

I don't envy the position the Congress finds itself in today. It is probably new in lots of ways for the Members to have been sent with such a strong mandate from the American people.

They have told you that we want change in our health care system, we want you to cover 34 million people who have no insurance, and at the same time we want you to cut the costs. It would seem at first that that could be in conflict, but it is not, and we believe that you can find one way to meet that challenge through home care.

Invacare Corp. is the world's largest manufacturer of home medical equipment. Our product lines include wheelchairs, both standard and prescription power and manual chairs, hospital-type beds for in-home use, home respiratory equipment and a variety of patient aids. Our products are saving money to this country every single day. Every product that we have that enables an individual to return to their home environment to resume a life of independence and to become once again live productive lives that in many cases generates money.

Congress cannot afford to turn its back on home care. I feel like the cleanup batter on the home team going into the 9th inning with a 10-run lead. There is not much I can say today that is going to do anything to sway you about home care that you haven't heard already. My colleagues have given me the advantage of being able to bring a couple other issues to the table.

As a manufacturer, and as my colleague Don here is a dealer, we face a real serious problem, if indeed the Congress gives serious consideration to caps and price freezes. As a manufacturer, we cannot control what the steel companies are going to charge us for steel or what the companies are going to charge us for bolts or electronics parts. But if you cap what you are going to pay for products, we can't recoup that money.

We have 3,000 employees worldwide and they have a right to expect a fair and equitable wage that keeps pace with inflation. But if prices are frozen, we may not be able to do that, or, worse yet, American manufacturers could be forced to look offshore for cheaper labor costs. That would be self-defeating. You wouldn't have any more money for health care, if you had fewer people paying taxes.

These are critical issues for manufacturers. For dealers, we have got another problem that Congress holds the key to, and that is the issue of streamlining the system. We have small dealers who report to us that spend 30 percent of their time filling out insurance forms and Medicare reports. That is pretty unproductive time. Two large multistate dealers report that 20 percent of their employees are in

claims and collection. That is 20 percent of the cost of a wheelchair. That is 20 percent of the cost of a respirator.

You can get control of that by simply saying enough is enough. The bureaucracy is out of control. Simple things, like electronic claims processing and so forth can reduce the cost of health care and give you some of the resources to reach those 37 million people without insurance. Maybe they cannot answer the whole problem, but they sure can help a lot.

You have heard enough about home care today, that you have got to know that it is cost-effective. You have got to know that it is the answer in most cases to long-term care, that it can meet the needs of people in an environment that is humane, that is safe and that yields good results.

You know from today's testimony that home care is an acute care solution. People need not spend days on end in hospitals recovering, when they can be treated at home. People waiting cardiac transplant surgery at the Cleveland Clinic wait at home, instead of in an intensive care unit at a cost of \$200 a day, rather than \$2,000 a day in the facility. That is a pretty dramatic example of the acute care possibilities of home care.

I want to again thank the committee and let them know that Invacare Corporation and myself stand ready to provide you information on home care and on home medical equipment. We want to be part of the solution, because the problem you are facing is a pretty big one.

Thank you.

[The prepared statement follows:]



**TESTIMONY OF DAVID T. WILLIAMS**  
**Invacare Corporation**

Good morning, Mr. Chairman and members of the Committee. My name is Dave Williams and I am Corporate Director of Communications and Public/Government Relations for Invacare Corporation. I want to express my gratitude to this Committee for providing this opportunity to make sure that home care is part of the dialogue on health care reform.

For those of you who do not know Invacare, we are the largest manufacturer and distributor of home medical equipment in the world. We make wheelchairs, ambulatory aids, home care beds, respiratory devices and bathroom safety products, among other things. Our headquarters are in Elyria, Ohio (outside Cleveland), but we also have plants in Florida, California, Canada, Mexico, Great Britain, Germany and France. Besides the various countries where we have local operations, there are roughly 60 other countries to which we export our products.

This Congress and the Administration have been given a tremendous assignment by the American people. You have been told to "reform" our health care system and find a way to extend its benefits to the 37 million people who have no health insurance. At the same time, you have been directed to reduce the costs of health care. While these charges may seem in direct conflict, that need not be the case. I am here because Invacare, as a leader in the home care industry, is committed to helping policy makers understand that home care can be a tool that proves useful in accomplishing the mission before you.

Hopefully, this testimony will provide you with some background on home care and stimulate your curiosity to look further at this means of providing cost effective, clinically appropriate health care. We believe that, when you do, you will arrive at the inescapable conclusion that home care must be part of any standard benefit package arising from the current debate on health care reform. We know that, as you look for ways to reduce health care costs, you will recognize that home care can help you achieve that objective. We are confident that, as you learn more about today's home care, you will come to see it as an appropriate tool for addressing both chronic and acute health care needs.

For those who are not familiar with today's home care and, for the record, let me provide a snap-shot. Home care is equipment such as manual and power wheelchairs, walkers, patient lifts, oxygen concentrators and numerous other items that make it possible for people to deal with illness, injury, disability or chronic health conditions in their home surrounded by family and friends. Home care is trained health care professionals providing services like physical therapy, respiratory care, intravenous therapy, nursing services and home maker assistance in such a way as to equal or exceed the level and quality of services in facilities like hospitals and nursing homes. Home care is clinically appropriate health care that often yields better patient outcomes than facility based services. Home care is excellent health care delivered in an environment that patients prefer at a fraction of the cost of facility based care.

Invacare's message will focus on the inseparable linkage between current financial and medical trends affecting home health care and demographic trends affecting older Americans, citizens with disabilities and health care consumers in general. There are dozens of trends, and they're all swirling at once like a tornado. But there are a few major ones that clearly show why future domestic policy should favor home care. These trends include: slow population growth and an aging population; rising health care costs; inadequate access to health care; and issues relating to the quality of health care (including its outcome and delivery).

For many of you this will be a review, but let's start by looking at rising costs. In 1970, U.S. health expenditures were \$74.4 billion. Since then, those costs have grown at an annual



rate of 11.6%, nearly three percentage points faster than our gross domestic product, to a total figure that approached \$700 billion in 1990.

During that same 20-year period, from 1970 to 1990, health care consumer pricing increased 400%. That's pretty hefty when you consider that the aggregate consumer price index increased 250%, heftier still knowing that median wages increased only 200% during that time. Health care spending in the United States is the highest in the world. It has been growing faster than spending in other major countries, and the gap between us and other countries is widening.

Moreover, the rate of increase is accelerating. Expenditures are expected to represent more than 16% of the gross domestic product at the turn of the century. By way of comparison, health care costs as a percent of GDP from 1970 to 1990 grew only from 5.5% to 8.1% in Germany, from 1.4% to 6.5% in Japan and from 4.5% to 6.2% in the United Kingdom. Employers in those countries obviously carry a much smaller health care burden than their American counterparts giving them a competitive advantage when it comes to the cost of labor.

Now is not the time to get into much detail about the causes of this phenomenon. In brief, over-utilization, under-utilization, lack of preventive care, and a burdensome bureaucracy have all contributed. In addition, "health care dollars" are used to subsidize the exorbitant expenditures for product liability and medical malpractice insurance made necessary by a virtual explosion in the area of health care litigation.

The inaccessibility of health care to 37 million Americans is inexcusable. Although U.S. health expenditures have grown dramatically, we have been unable to reduce the number of uninsured Americans or to substantially improve the crude health statistics for the nation's population. In fact, the percentage of people with no insurance actually increased 21% between 1978 and 1989.

Americans without any type of health insurance defy stereotypes. They represent a true cross section of the nation. Non-working adults account for only 16% of them. Nearly two-thirds of the uninsured are in families of employed workers, almost half of whom are self-employed or work for companies with less than 25 employees. Health insurance has become so expensive that many employers cannot afford to offer it.

Small wonder that the need for national health care reform has become an issue of such prominence. Indeed, it rose to the top of the public policy agenda in last fall's elections, ranking second in importance as a campaign issue with voters behind only the economy.

Now let's take a look at one of the primary consumer groups for health care in America -- older people. Americans are living longer lives than ever before. In 1776, a child born in America could expect to live only to age 35, on the average. But times have changed. Extraordinary breakthroughs in health care have eliminated many of the diseases that used to claim the lives of early settlers. Smallpox is gone. Cholera is almost nonexistent. The death rate from tuberculosis has been reduced by over 99.9%.

A child born in the U.S. today can expect to live to age 75 and a half. Government statisticians estimate that medical advances will tack on two more years by 2010. In the coming decade, the median age of the U.S. population will go from 33 years to 36 years. What does that mean? In the 1920's, one American in 25 was over the age of 65. Today, it's one in eight. By 2050, if the Census Bureau's projections are correct, almost one American in four will be eligible for Social Security under today's rules.

While the current decade will see very little change in the number of Americans aged 65-74, there will be dramatic gains in the number of those older than 74. Today's group of 10 million 75-84 year olds will grow in size by 21%. And the number of Americans who are over 85 will increase from its current number of three million by 42%.

So, not only do we have escalating national health care costs, but we also can expect a dramatic rise in the number of people who need extensive medical care. This is quite a challenge. But there is good news in the form of patterns of change in where people, both old and young, go for their health care.

There is a shifting emphasis away from inpatient health care in the United States toward community-based ambulatory care. Hospital patients here are going home "quicker and sicker" than ever before.

The U.S. Department of Commerce reports that from 1979 to 1990, hospital inpatient admissions declined by 10%, while outpatient visits grew nearly 44%, clearly indicating this trend. Average length of hospital stay declined 11% between 1970 and 1990, but hospital and physician costs increased more than 650% during that time.

Today's health care payers are pressuring "the system," searching for medically viable, cost-effective alternatives. Employers, unions, HMO's, PPO's, insurance companies, Medicare, Medicaid and even patients themselves are all on the bandwagon calling for change.

And with the average hospital stays ranging anywhere from \$600 to \$800 per day and at-home care averaging around \$200 per day, it's no wonder that the scales are tipping in favor of home care.

Home care also offers tremendous emotional advantages to many people who benefit from the support of family members and the comfort of a familiar environment. The National Association of Medical Equipment Suppliers (NAMES) conducted national research on peoples' attitudes about home health care. Not surprisingly, they found that three out of four Americans would prefer to be taken care of at home when recuperating from a serious accident or illness. And, lest you think the NAMES survey might be self-serving, the Governor of Ohio reported last month that a state poll revealed that 90% of the people surveyed would prefer to receive health care in their homes.

Additionally, there has been a dramatic surge in the availability of home care services. At a time when many industries have shown declines in job growth, the U.S. Bureau of Labor Statistics reported a whopping 192% increase in jobs in the home health care industry during 1990. Industry experts estimate home health care to be a \$15 billion dollar industry with double-digit growth that is expected to continue well into the next century as those born after World War II grow older.

Advances in technology have made medical equipment and medical services more sophisticated and more widely available for home use. For example, respiratory therapy for AIDS patients and intravenous therapy that were previously available only in medical institutions are now routinely administered at home. Computerized electronic controls on power wheelchairs have allowed many people with quadriplegia to function independently, without an attendant. Independent community home health programs that deliver a comprehensive array of home health services are expanding rapidly.

And, on a growing basis, hospitals are impacting this trend as they develop and expand quality home care services for their patients. The American Hospital Association reports that over 30%

of the nation's hospitals have a home health care program, nearly three times as many as in 1980.

There are new programs taking shape in a number of innovative and exciting ways. For example, pro-active hospital discharge planning programs are becoming more sophisticated and more widespread. Hartford Hospital has a program that is an outstanding, highly organized example of how hospitals can provide continuing care and timely, achievable, quality discharge plans for patients.

There are other hospital-based home care organizations like The Cleveland Clinic, which has a home care program, that, among other things, takes care of patients awaiting heart transplant surgery. Instead of leaving these patients in intensive care units at a cost of thousands of dollars a day for up to six months, care is provided in their homes. Technology enables these patients to receive intravenous antibiotics and other drugs at home to prepare them for their surgery. If necessary, home respiratory care is available and equipment designed to assist the patient and their family in a variety of ways. All this makes it possible for people awaiting transplant surgery to get care at home that meets or exceeds the quality of care they would receive in the hospital.

Clinic surgeons report that patient survival and recovery is enhanced by home care. They arrive in surgery in better spirits, with a positive attitude knowing that they can still be part of their home and family.

Another innovative model can be found at the Cooperative Care Center for New York University's Medical Center. NYU's program is characterized by a live-in family member or friend acting as a "care partner" during acute inpatient care. It has an emphasis on education, encouraging full patient and family involvement in care during the hospitalization, thereby preparing both parties for management at home after discharge.

So far, we've reviewed the soaring cost of health care in this country and the problems with lack of access to medical care due to the millions who have no health insurance. We've talked about the aging of the U.S. population. We've heard that Americans prefer to get medical care at home when it's feasible. And we've talked about the advances in home medical technologies and the pressures that exist from health care payers to reduce costs.

With all of this as background, it is clear that the importance of legislation and public policy in support of the nation's home care needs for all Americans is critical.

It is indeed disappointing that many in the Congress and Administration do not yet understand the cost-effectiveness of home care, or how it relates to the entire continuum of care. Some still view home care as additive to the already escalating health care bill. Others misunderstand home care, viewing it as an alternative only to chronic care and nursing home situations, failing to realize its viability in acute care situations.

While most home care involves chronic problems that are not life-threatening, and while this segment of home care continues to grow along with our aging population, more and more physicians at the frontiers are expanding their work to include acute, complex situations. For example, an article in the New York Times talked about a 6-month old infant in Chicago with severe spinal cord injuries -- who could not suck, breathe, cry, or even move on her own -- and who was discharged from a hospital intensive care unit to be at home with her family. While this particular case may be an extreme example, it nevertheless illustrates my point about the advances in home care. If this child can be served in home, think of the thousands of individuals in facility based programs who could benefit from home nursing and advanced home medical



equipment. Technology is enabling the development and rehabilitation of an acute care patient in a home care environment and the number and types of medical conditions that can be cared for in the home increase nearly every day.

Perhaps one of the reasons that many in Washington have yet to recognize the value of home care is that there has been very little empirical data produced to show its actual cost effectiveness.

One such research study was conducted by Lewin/ICF in March 1991 for three trade associations: the National Association of Medical Equipment Suppliers (NAMES); the Health Industry Distributors Association (HIDA); and the Health Industry Manufacturers Association (HIMA). This study analyzed the cost effectiveness of hospital therapy versus home therapy under three separate medical conditions: hip fractures; Amyotrophic Lateral Sclerosis (ALS) with pneumonia; and Chronic Obstructive Pulmonary Disease (COPD).

In hip fractures, home care resulted in a dramatic average savings of \$2,300 per episode. Multiplying that by the national prevalence of 250,000 cases results in \$575 million in total annual savings which could be realized if home care were applied routinely in cases of hip fracture.

In ALS with pneumonia, the savings per episode were \$300, or \$459,000 for 1,500 cases annually.

In COPD, the savings per episode were \$520, or \$48 million dollars for 93,000 cases annually.

The Home Care Coalition -- a group representing manufacturers, dealers and direct care providers -- cites similar potential savings. They project that it would cost \$61,000 to care for an infant born with breathing and feeding problems in the hospital versus \$20,000 if cared for at home and \$23,000 for ventilator-dependent patient care in the hospital versus \$1,700 at home.

As the ongoing debate on national health care reform unfolds, government awareness will grow and public opinion will become even more focused on how home care can be part of the solution to the nation's soaring health care costs. Home care also holds much promise as a tool for helping meet the challenge of providing access to health care for those currently without insurance.

Yet today, a variety of questions must be addressed in order to facilitate growth of home care. Do today's multiple, varied reimbursement systems motivate the most cost effective medical choices, or do we need to revise them? We think the answer is an obvious yes.

Is home care truly more cost effective than inpatient care? Our data shows that it is.

Are physicians available for at-home care? They must change in many ways if reform is to work and physicians may not be either the most appropriate or cost effective people to provide many home care services.

Can nurses do more than they are legally allowed to do today? If nurses were permitted to provide greater levels of care than today's laws permit, we could see a dramatic impact in the form of lowered costs and improved access.

What about the 30-40% vacancies and under-utilized overhead that exist in our nation's hospitals today? We can't thwart progress to preserve an outdated dysfunctional system.



And finally, how can we be sure that the home care industry is capable of providing quality care and is it willing to be held as accountable as traditional care providers? We can provide a prompt and unwavering response to that question.

Invacare and the entire home care industry want Congress and the appropriate administrative agencies to stipulate strong quality outcome indicators for home care products and services. We are aware that a collective lack of knowledge about home care often translates into a lack of confidence. However, we are confident that our products and services can meet or exceed all reasonable quality indicators. Collectively, the home care industry has supported every effort to rid our nation of the very few unscrupulous equipment vendors and service providers who engage in fraudulent or abusive activities.

The industry was on record as supporting the fraud and abuse provisions contained in H.R. 11 which was vetoed by President Bush last November and we support the provisions contained in H.R. 21, introduced by Congressman Rostenkowski this year. We believe that strong, clear and enforceable quality indicators can be one more tool in the effort to combat fraud and abuse in the home care industry.

Before concluding this testimony, it is appropriate to comment on cost containment from the manufacturer's perspective and to offer an observation on one costly aspect of the current system.

There has been a lot of talk about capping expenditures and freezing prices as a means of reining in the costs of health care. As you consider these options, please remember the impact that such measures can have on a company like Invacare.

Congress has the ability to cap Medicare and Medicaid payments for specific items. History has shown that private insurers follow your lead. But such measures fail to take into account the costs of manufacturing. Invacare can't control what our suppliers charge us and our employees rightfully expect that their wages remain competitive and keep pace with inflation.

Price freezes and spending caps on manufactured goods are penny wise and pound foolish. While they may hold some attraction for short-term cost reductions, they could result in job reductions at medical equipment manufacturers and enable off-shore companies to take bigger market shares from American companies. Worse yet, prolonged price freezes or artificial spending caps that do not take into account the impact of inflation on manufacturing costs could force some manufacturers to relocate plants outside the United States. Congress must be very thoughtful and evaluate the actual long term benefits of such actions and acknowledge the very real possibility that price freezes on medical equipment could inflict a serious blow on the health of several American companies and therefore, the U.S. economy.

As a manufacturer of home medical equipment (HME), Invacare encourages Congress to include coverage for home care in any standard benefit package -- and Invacare is not alone. The latest proposal of the Jackson Hole Group for designing the Initial Uniform Effective Health Benefit Plan (March 1993) includes a recommendation that coverage for home care services and equipment be part of every American's basic health care benefits. While HME is "covered" under Medicare and Medicaid, Congress must learn from past practices that have denied access to technology that can ameliorate the effects of illness or disability to many people in the name of cost containment.

While the initial outlay for state-of-the-art technology may seem high, experience has proven time and time again that these are wise investments. Still, current Medicare regulations discourage consumers from "upgrading" to the best equipment by supplementing

the Medicare allowable with their own resources. The HME industry has sought the opportunity to conduct a pilot demonstration concerning this type of "patient choice program" but has been repeatedly rebuffed by the HCFA bureaucracy. Hopefully, any HME coverage adopted as part of the current national reform effort will be written in such a way as to insure access to appropriate technology and permit upgrades where appropriate for all Americans.

The home care industry has long contended that red tape and huge bureaucracies are a significant cause of the high cost of health care. Several small Invacare dealers report that they spend as much as 30% of their time on insurance forms and Medicare reports. Two of our largest multi-state dealers state that 20% of their employees work full time in the billing and collection department. Reducing some of the redundant reporting requirements and implementing systemic improvements, such as electronic claims processing, would make a significant contribution to any cost reduction efforts.

In closing, one might ask how national policy reform can address the immense challenges at hand of improving health care coverage for the nation's 37 million uninsured people while simultaneously reducing its health care costs that have risen more than 75% in the past five years? Home care is, at least in part, an important answer to that question.

There was a time in this country when home care was commonplace. Family doctors made routine house calls, delivered babies, set broken bones and treated pneumonia in people's homes. If health care reform is to succeed in providing coverage to uninsured Americans and reducing costs, home care will be returning, albeit in a very different light, to these roots.

That is why it is now incumbent on Congress and the Administration to make certain that home care is a key component of any standard benefit package enacted in the 103d Congress. As the debate continues, please be assured that Invacare Corporation stands ready to work with Congress and the Administration to provide any information and assistance.

Thank you for the opportunity to present our views. I would be pleased to respond to any questions.

Mr. KLECZKA. Thank you, Mr. Williams, for your comments.  
Mr. Stewart Bainum, from Manor Healthcare Corp., Silver Spring, Md.

**STATEMENT OF STEWART BAINUM, JR., CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, MANOR HEALTHCARE CORP., SILVER SPRING, MD.**

Mr. BAINUM. Thank you, Mr. Chairman.

As you said, Mr. Chairman, my name is Stewart Bainum and I am chairman and chief executive officer of Manor Care. Our subsidiary, Manor Healthcare Corp., is a provider of long-term care services in 28 States across the country. We operate 166 skilled nursing facilities, serving just over 20,000 residents.

Last year, we provided approximately three-quarters of a million Medicare and 2.4 million Medicaid patient days. On behalf of our 23,000 employees, our 20,000 residents and nearly 15,000 owners, I want to thank you, Mr. Chairman, and the subcommittee members for allowing us to testify here this afternoon.

I am here to call to your attention a new service which I encourage you to include in the basic benefit package, subacute care. Subacute care makes the most effective care setting the rule, rather than the exception, and it does so without compromising quality in any way. Subacute care offers short-term care between acute critical care in the hospital setting and skilled nursing care rendered in long-term care facilities.

The goal is to improve the patient's physical abilities and to decrease the amount of medical intervention in the shortest time possible, usually 30 to 60 days. Cost effectiveness is realized as acute hospital stays for these patients are markedly shorter.

The types of cases that are commonly cared for in a subacute facility are spinal cord injuries, head injuries, acute oncological care, neurological defects, major orthopedic cases, as well as other major trauma cases. The average age of subacute patients in our subacute units is 45.

Subacute care is expanding across the country, because insurance companies are searching for less costly alternatives to more expensive hospital-based care. Total daily charges, for example, in a subacute unit range from \$350 to about \$575 versus \$650 to \$1000 a day in an acute care hospital or a rehabilitation hospital.

If Congress should enact a flat rate or DRG-based system as part of health care reform, we would have reservations about hospitals without skilled nursing facility units becoming subacute providers. As the gatekeeper for the patient, the hospital may have an inherent conflict of interest in determining how quickly patients are discharged from its acute care unit to its subacute unit.

Our concern, Mr. Chairman, is that acute care patients might be transferred prematurely by the hospital to its subacute care unit, allowing the hospital to be reimbursed two times, once for an acute care DRG and then secondly for subacute care. Some hospitals might also attempt to place as many patients as possible into these units, leading to in some cases to unjustified utilization and reimbursement.

So we believe that cost savings will not occur, if hospitals are allowed to offer subacute care. We feel any subacute care benefits

should be restricted to freestanding and hospital-based skilled nursing facilities. I suspect this might sound somewhat self-serving to you, but we also believe that it is in the public interest, because it will save literally hundreds of millions of dollars a year of taxpayers' money.

Mr. Chairman, I want to thank you for your consideration of cost-effective subacute care, and I would ask that my complete written testimony be made a part of the record.

[The prepared statement follows:]



**STATEMENT OF STEWART BAINUM, JR., MANOR HEALTHCARE CORP.**

GOOD MORNING MR. CHAIRMAN. MY NAME IS STEWART BAINUM, JR. AND I AM CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER OF MANOR CARE, INC. OUR SUBSIDIARY, MANOR HEALTHCARE CORP., IS A PREMIER PROVIDER OF LONG TERM CARE SERVICES. WE OWN AND OPERATE 166 FACILITIES NATIONWIDE, SERVING APPROXIMATELY 20,000 RESIDENTS. LAST YEAR, WE PROVIDED APPROXIMATELY 722,000 MEDICARE AND 2,419,000 MEDICAID PATIENT DAYS OF CARE.

THE TASK BEFORE YOUR SUBCOMMITTEE IS FORMIDABLE, AND I COMMEND YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE FOR YOUR DILIGENCE IN HOLDING THESE HEARINGS TODAY. DETERMINING WHAT CONSTITUTES THE BASIC BENEFIT PACKAGE IS AMONG THE MOST DIFFICULT ASPECTS OF HEALTH CARE REFORM.

THIS DECISION WILL HAVE GREAT FINANCIAL AND SOCIAL IMPORTANCE. A NARROWLY DRAWN BENEFIT PACKAGE CAN SAVE BILLIONS OF DOLLARS, BUT FORECLOSE ACCESS TO A NUMBER OF IMPORTANT SERVICES. AT THE OTHER EXTREME, A BROAD-BASED BENEFIT PACKAGE COULD FURTHER BREAK AN ALREADY BROKEN BANK.

I AM HERE TODAY TO CALL TO YOUR ATTENTION A NEW SERVICE, WHICH I ENCOURAGE YOU TO INCLUDE IN THE BASIC PACKAGE -- SUBACUTE CARE. I AM VERY ENTHUSIASTIC ABOUT THIS LEVEL OF CARE, BECAUSE IT MAKES THE MOST COST-EFFECTIVE CARE SETTING THE "RULE RATHER THAN THE EXCEPTION," AND IT DOES SO WITHOUT COMPROMISING QUALITY.

SUBACUTE CARE OFFERS SHORT-TERM CARE BETWEEN ACUTE/CRITICAL CARE IN HOSPITALS AND SKILLED NURSING CARE RENDERED IN LONG TERM CARE FACILITIES. THE GOAL IS TO IMPROVE THE PATIENT'S PHYSICAL ABILITIES AND DECREASE THE AMOUNT OF MEDICAL INTERVENTION IN THE SHORTEST TIME POSSIBLE, USUALLY 30 TO 60 DAYS. COST EFFECTIVENESS IS REALIZED, AS ACUTE HOSPITAL STAYS FOR THESE PATIENTS ARE SHORTENED.

OBVIOUSLY, NOT ALL HOSPITALIZED INDIVIDUALS WOULD QUALIFY FOR OR BENEFIT FROM SUBACUTE SERVICES, SINCE THEY ARE HIGHLY SKILLED AND FAIRLY INTENSIVE. SUBACUTE SERVICES ARE MULTIDISCIPLINARY, INVOLVING

MANY PROFESSIONS, SUCH AS PHYSIATRISTS, NEUROPSYCHOLOGISTS, NURSES, RESPIRATORY THERAPISTS, OCCUPATIONAL THERAPISTS, AND DIETICIANS. THE MAJORITY OF THE NURSING CARE IS PROVIDED BY LICENSED NURSING STAFF. IN ADDITION, CASE MANAGERS ARE UTILIZED TO OPTIMIZE THE BENEFITS FROM THE INTENSIVE SERVICES.

WHILE COVERAGE SHOULD NOT BE LIMITED TO A SPECIFIC CATEGORY OR DIAGNOSTIC CLASSIFICATION OF PATIENTS, THE FOLLOWING ARE TYPES OF CASES THAT COMMONLY ARE CARED FOR IN A SUBACUTE FACILITY: SPINAL CORD AND HEAD INJURIES, ACUTE ONCOLOGICAL CARE, MAJOR ORTHOPEDIC CARE, OTHER MAJOR TRAUMA CASES, AND PATIENTS WITH NEUROLOGICAL DEFICITS.

THE AVERAGE AGE OF PATIENTS IN OUR SUBACUTE UNITS IS 45 YEARS, WHICH CLEARLY DEMONSTRATES THAT THE NEED FOR SUCH SERVICES IS NOT LIMITED TO THE ELDERLY.

THE REASON WHY SUBACUTE CARE IS EXPANDING IS BECAUSE INSURANCE COMPANIES ARE LOOKING FOR ALTERNATIVES THAT ARE LESS COSTLY THAN HOSPITALS. ON AVERAGE, TOTAL DAILY CHARGES (INCLUDING ANCILLARY SERVICES) IN A SUBACUTE UNIT RANGE FROM \$350 TO \$575 PER DAY, VERSUS \$650 TO \$1000 PER DAY IN AN ACUTE GENERAL OR REHABILITATION HOSPITAL. TWO OF OUR SUBACUTE UNITS ARE LOCATED IN THE PHILADELPHIA AND BALTIMORE MARKETS. A COMPARISON OF OUR BASIC SEMI-PRIVATE ROOM CHARGES TO SOME AREA HOSPITALS' CHARGES (EXCLUDING ANCILLARY SERVICES) CLEARLY ILLUSTRATES THE PRICE DIFFERENTIALS.

#### PHILADELPHIA

MHC MEDBRIDGE UNIT	\$200
HAHNEMANN HOSPITAL	\$820
ABINGTON HOSPITAL	\$875
HOLY REDEEMER HOSPITAL	\$837

#### BALTIMORE

MHC MEDBRIDGE UNIT	\$200
SINAI HOSPITAL	\$491
JOHNS HOPKINS HOSPITAL	\$451
GREATER BALTIMORE MEDICAL CENTER	\$434

THESE FIGURES DO NOT REPRESENT PRICE DIFFERENTIALS FOR VARIOUS SERVICES, LIKE PHYSICAL AND OCCUPATIONAL THERAPIES, OR PRODUCTS, SUCH AS OXYGEN, CATHETERS, AND TRACHEOTOMY KITS. NEVERTHELESS, THESE NUMBERS DEMONSTRATE THE POTENTIAL SAVINGS IN HEALTH CARE COSTS IF SUBACUTE UNITS ARE UTILIZED.

IF CONGRESS ENACTS, FOR EXAMPLE, A FLAT RATE OR DRG BASED SYSTEM, I HAVE VERY SERIOUS RESERVATIONS ABOUT HOSPITALS BECOMING SUBACUTE PROVIDERS. MY CONCERN IS THAT ACUTE CARE PATIENTS MIGHT BE TRANSFERRED PREMATURELY INTO SUBACUTE CARE UNITS, ALLOWING HOSPITALS TO BE REIMBURSED TWICE. HOSPITALS MIGHT ALSO ATTEMPT TO PLACE AS MANY PATIENTS AS POSSIBLE INTO THESE UNITS, LEADING TO WIDESPREAD UTILIZATION AND REIMBURSEMENT. I BELIEVE COST SAVINGS WILL NOT OCCUR IF HOSPITALS OFFER SUBACUTE CARE. CONSEQUENTLY, I FEEL ANY SUBACUTE CARE BENEFIT SHOULD BE RESTRICTED TO FREESTANDING AND HOSPITAL-BASED SKILLED NURSING FACILITIES.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS MY SUPPORT FOR SUBACUTE CARE. AGAIN, I WOULD LIKE TO REITERATE MY ENTHUSIASM FOR SUBACUTE CARE BECAUSE THIS IS THE WAY TO RENDER HIGH QUALITY COST EFFECTIVE ALTERNATIVE CARE. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Mr. KLECZKA. Mr. Bainum, on your last point of the hospital referring their own acute patients to their own subacute facility, you have no problem if the transferring unit is owned by a subsidiary or a person other than the hospital?

Mr. BAINUM. I'm sorry, I did not understand the last part of your question.

Mr. KLECZKA. You voiced a conflict of interest, if, in fact, the hospital would transfer an acute patient to their own subacute facility. But if it is a freestanding facility and owned by another entity other than the hospital, at that point you would have no problem with it?

Mr. BAINUM. That is correct.

Mr. KLECZKA. It is the same issue we are talking about with physician referrals to their own laboratory facilities?

Mr. BAINUM. That is correct. I think the same principle is involved, because the hospital is the gatekeeper. As the gatekeeper, they have an inherent conflict of interest in determining where that patient ends up, if they end up in a health care facility or unit that they have an interest in or not.

Mr. KLECZKA. But who would be the gatekeeper, if in fact the hospital would be permitted to set up their own subacute unit?

Mr. BAINUM. Well, the hospital discharge planner I assume would assist in the decisionmaking process, as well as the payer.

Mr. KLECZKA. Thank you.

We will now hear from Ms. Deirdre Lawe, from VITAS Healthcare Corp.

#### **STATEMENT OF DEIRDRE LAWE, REGIONAL VICE PRESIDENT, VITAS HEALTHCARE CORP., MIAMI, FLA.**

Ms. LAWE. Thank you, Mr. Chairman.

As you said, my name is Deirdre Lawe, and I am a regional vice president with VITAS Healthcare Cor., of Miami, Fla. I have been a registered nurse for 15 years, with many years' experience in critical care nursing prior to working with VITAS for the past 6 years.

VITAS, the Nation's largest hospice provider, cares for patients in Florida, Illinois, Texas, Indiana, and Ohio and has been providing quality hospice care for 14 years. Every day, VITAS' more than 1,300 employees and hundreds of volunteers serve approximately 3,000 patients of all ages in their homes or in home-like settings.

Regardless of the setting, our consistent philosophy is that when a cure is no longer possible, terminally ill patients should be allowed the choice to live their remaining days comfortably, without pain, with personal dignity and close to their loved ones.

I am pleased to appear before you today to urge that the Medicare model of hospice be included as an essential element of the basic benefits package in any health care reform legislation. There is a continuing need to educate providers, particularly physicians and hospitals, as well as insurers about the hospice alternative to acute care.

While the elderly have access to hospice care through Medicare, including the hospice option as a basic benefit will encourage its development and expand its availability, so that dying people of all



ages in every part of this Nation will have the chance to access hospice care.

During the years I worked in critical care nursing, I had many occasions to witness the heart-wrenching ethical dilemma faced by physicians dealing with terminally ill patients. The alternatives were neglect or inappropriate and often unwanted overtreatment. This dilemma was the subject of a recent study by the Hastings Center that was published in the *American Journal of Public Health* in January of 1993. That study, which surveyed more than 1,400 physicians and nurses, found that four times as many respondents were concerned about overtreatment of patients than about undertreatment.

Since becoming a hospice nurse, I have learned that what is often most appropriate for terminally ill patients is expert palliative care which eliminates their pain and manages their symptoms. Care for dying people is a very distinctive medical specialty in and of itself. Hospice care, as defined under Medicare, meets special clinical needs for the terminally ill in a comprehensive and dignified way.

In fact, hospice offers a model for managing many complex medical situations, in addition to terminal illness. The essential characteristics of hospice make it a paradigm for providing higher quality, better managed care, with improved clinical outcomes at lower cost, and these characteristics of hospice care are quality of life.

Hospice delivers a comprehensive package of services tailored to the specific needs of each individual patient. As a hospice nurse, I work with a team of professionals from physicians to social workers and chaplains. The patients continue to have the physician of their choice as a member of our interdisciplinary team.

One of the most important examples of how hospice care improves the patient's quality of life is the effective management of pain. Chronic pain is a critical problem for the vast majority of terminally ill patients, despite the medical advances of the last few decades. The Hastings study I mentioned earlier also reported a substantial conflict between principle and practice in the area of pain control for dying patients.

Eighty-one percent of the medical professionals surveyed reported that the most common form of narcotic abuse in the case of the dying is the undertreatment of pain. Hospice, by contrast, has been a leader in developing pain control techniques. Clinical studies conducted at VITAS have demonstrated that our hospice care has demonstrably reduced pain in over 90 percent of our cases.

**Cost:** The costs associated with caring for terminally ill patients through nonhospice acute care providers are stunning. As you know, HCFA has reported that people in their last 180 days of life account for more than one-fourth of all Medicare outlays and more than one-fourth of all Medicare-paid hospital days. HCFA studies indicate that a patient in the last 60 days of life is hospitalized an average of 21 days. For patients electing hospice care, the results are actually reversed. The vast majority of hospice patients spend fewer than 10 days in inpatient settings during the last few months of life.

Another important element of the Medicare hospice benefit helps not only to control costs, but to better manage the patient's condi-

tion. When a patient makes the choice to select the hospice benefit, he or she waives eligibility for other health care benefits related to the terminal illness. This avoids hospitalization and eliminates multiple providers and costs associated therewith, as well as requiring one provider to assume full responsibility for case management. Also, because hospice providers are paid one all-inclusive rate per patient on a prospectively determined per diem basis, we have an incentive to use resources efficiently, in contrast to utilization-driven medical providers.

Frequently, we care for patients who had previously been shuttled back and forth to the emergency room every few weeks, with expensive hospital admissions lasting several days at a time. With hospice care, these patients can remain at home, if at all possible.

Accessibility: As a hospice nurse, I have seen a young patient suffering from lung cancer who desperately wanted to spend her last days at home with her family. She was denied the choice, because her insurance plan covered acute care hospitalization only, but it did not cover less expensive hospice services. When the patient was finally able to convince her insurer to allow her to go home, we were able to effectively manage her symptoms and improve her quality of life. Including hospice care as a basic benefit will help eliminate barriers to access such as this.

The last characteristic is innovation: Hospice offers innovative methods of caring for patients with complex medical conditions such as AIDS. In fact, VITAS is one of the largest providers of hospice care to AIDS patients. We have created a separate service called the "Outreach Program" that has cared for over 2,000 people with AIDS who need more high-tech and expensive forms of palliative care to avoid repetitive hospitalization.

The Outreach Program combines these high-tech forms of care with the more intensively staffed psychosocial program that is multicultural and stigma-sensitive. By investing in a more intensive level of hospice care for AIDS patients, Congress could obtain a less expensive substitute for hospital-based care.

In her April 6, 1993 remarks at the University of Texas, Hillary Rodham Clinton asked: "How do we create a system that gets rid of the micromanagement and the regulation and the bureaucracy, and substitutes instead human caring, concern and love—that is our real challenge in redefining our health care system."

We believe that hospice is an essential element in responding to that challenge.

Thank you, Mr. Chairman.

[The prepared statement follows:]



**STATEMENT OF DEIDRE LAWE, ON BEHALF OF VITAS HEALTHCARE  
CORP.**

Chairman Stark and Members of the Subcommittee, my name is Deirdre Lawe and I am a Regional Vice President of VITAS Healthcare Corporation of Miami, Florida. I have been a registered nurse for 15 years with many years experience in critical care nursing prior to working with VITAS for the past 6 years.

VITAS, the nation's largest hospice provider, cares for patients in Florida, Illinois, Indiana, Ohio, and Texas, and has been providing quality hospice care for over 14 years. Every day VITAS' more than 1,350 employees and hundreds of volunteers serve approximately 3,000 patients of all ages in their homes or in homelike settings.

Regardless of the setting, our consistent philosophy is that when a cure is no longer possible, terminally ill patients should be allowed the choice to live their remaining days comfortably, without pain, with personal dignity, and close to their loved ones.

I am pleased to appear before you today to urge that the Medicare model of hospice be included as an essential element of the basic benefit package in any health care reform legislation.

Hospice in this country is young and still dominated by the grass roots organizations that were involved at its inception. Thanks to you Mr. Stark and many of your former colleagues such as Mr. Panetta and Mr. Gradison, who were pioneers in its development, hospice is available to dying people as an appropriate and humane alternative to the acute care system. There is a continuing need to educate providers, particularly physicians and hospitals, as well as insurers about the hospice alternative to acute care. While the elderly have access to hospice care through Medicare, including the hospice option as a basic benefit will encourage its development and expand its availability so that dying people of all ages in every part of this nation will have the chance to access hospice care.

During the years that I worked in critical care nursing, I had many occasions to witness the heart-wrenching ethical dilemma faced by physicians dealing with terminally ill patients. The alternatives were neglect or inappropriate, and often unwanted overtreatment. The dilemma that results in overly-burdensome, unnecessary treatment is the subject of a recent study by the Hastings Center that was published in The American Journal of Public Health in January 1993. That study, which surveyed more than 1400 physicians and nurses, found that four times as many respondents were concerned about overtreatment of patients than about undertreatment.

Since becoming a hospice nurse, I have learned that there is another and better choice in such cases. What is most often appropriate for terminally ill patients is expert palliative care which eliminates their pain and manages their symptoms. When a patient selects hospice care, he or she eliminates the painful intrusive procedures that acute care hospitalization might necessitate. Instead, hospice care provides the opportunity to select an enhanced quality of life through appropriate palliative care.

Caring for dying people is a very distinctive medical specialty in and of itself. Hospice care, as defined under Medicare, meets the special clinical needs for the terminally ill in a comprehensive and dignified way.

In my remarks this morning, I would like to describe what I have learned about the advantages of hospice. I think these advantages make hospice such an effective example of managed care that it can become a model for managing many complex medical situations in addition to terminal illness. In many such cases, low technology medical treatment, coupled with substantial and continuous professional attention to the patient's emotional and psychological needs, provides the optimum medical outcome.

In fact, the essential characteristics of hospice make it a paradigm for providing higher quality, better managed care, with improved clinical outcomes at lower cost.

These characteristics are:

1. Quality of Life - Hospice delivers a comprehensive package of services tailored to the specific needs of each individual patient. As a hospice nurse, I work with a team of professionals from physicians to social workers and chaplains. I think one of the most important examples of how hospice care improves the patient's quality of life is the effective management of chronic pain. Chronic pain is a critical problem for the vast majority of terminally ill patients, despite the medical advances of the last few decades. The Hastings study that I mentioned before also reported a substantial conflict between principle and practice in the area of pain control for dying patients. Eighty-one percent (81%) of the medical professionals surveyed reported that "the most common form of narcotic abuse in the case of the dying is the undertreatment of pain."

Hospice, by contrast, has been a leader in developing pain control techniques. Clinical studies conducted at VITAS have demonstrated that our hospice care has demonstrably reduced pain in over 90% of cases.

2. Cost - The costs associated with caring for terminal patients through non-hospice, acute care providers are stunning. The Health Care Financing Administration ("HCFA") has reported that people in their last 180 days of life account for more than one-fourth of all Medicare outlays and more than one-fourth of all Medicare-paid hospital days. HCFA studies indicate that a patient in the last 60 days of life is hospitalized an average of 21 days. For patients electing hospice care, the results are reversed. The vast majority of hospice patients spend fewer than 10 days in inpatient settings during the last 60 days of life.

If a patient, for example, is cared for by hospice during the last sixty days of life and uses ten days of inpatient service, the cost of care including pharmaceuticals would be approximately \$9000. If the same patient is hospitalized twenty-one days, at \$1000 per day, which is a conservative estimate, the cost would be \$21,000 for the hospital care alone -- a striking difference.

Another important element of the Medicare hospice benefit helps not only to control costs, but to better manage the patient's condition. When a patient makes the conscious choice to select the Medicare hospice benefit, he or she waives eligibility for all other health care benefits related to the terminal illness. This avoids hospitalization and eliminates multiple providers and the costs associated therewith as well as requiring one provider to assume full responsibility for case management. Also, because hospice providers are paid one all-inclusive rate per patient on a prospectively-determined per diem basis, we have an incentive to use resources efficiently in contrast to utilization-driven medical providers.

Frequently, we care for patients who had previously been shuttled back and forth to the emergency room every few weeks with expensive hospital admissions lasting several days at a time. With hospice care, these patients can instead be at home without the expensive, disruptive and



disorienting experience of periodic hospitalizations. With the help of our staff and family or neighbor volunteers whom VITAS has trained, patients can choose to live at home with enhanced psychological and physical comfort at tremendous cost savings over the acute care option.

3. Accessibility - As a hospice nurse, I have seen a young patient suffering from lung cancer who desperately wanted to spend her last days at home with her family. She was denied the choice because her insurance plan covered acute care hospitalization including high dose intravenous morphine which cost approximately \$1,000 a day, but it did not cover less expensive hospice services. When the patient was finally able to convince her insurer to allow her to go home, we were able to effectively manage her symptoms and improve the quality of her life. Including hospice care as a basic benefit will help eliminate barriers to access such as this.
4. Innovation - Hospice offers innovative methods of caring for patients with complex and costly diseases like AIDS. In fact, VITAS is one of the largest providers of hospice care to AIDS' patients. We have created a separate service called the "Outreach Program" that has cared for over 2,000 people with AIDS who need more high tech forms of palliative care to avoid repetitive hospitalization. The Outreach Program combines these high tech forms of home care with a more intensively staffed psychosocial program that is multicultural and stigma sensitive. Inpatient services are also made available as needed. By investing in a more intensive level of hospice care for AIDS patients, Congress would obtain a less expensive substitute for hospital-based care.

In her April 6, 1993, remarks at the University of Texas, Hillary Rodham Clinton asked: "How do we create a system that gets rid of the micro-management and the regulation and the bureaucracy, and substitutes instead human caring, concern and love -- that is our real challenge in redefining our health care system." We believe that hospice is an essential element in responding to that challenge.

Mr. KLECZKA. Thank you, Ms. Lawe.

The last witness today will be the Association of Organ Procurement Organizations, Ms. Rebecca Davis.

**STATEMENT OF REBECCA J. DAVIS, M.H.A., PRESIDENT, LIFEGIFT ORGAN DONATION CENTER, TEXAS MEDICAL CENTER, HOUSTON, TEX., AND CHAIRMAN, LEGISLATIVE COMMITTEE, ASSOCIATION OF ORGAN PROCUREMENT ORGANIZATIONS**

Ms. DAVIS. Thank you, and good afternoon, Mr. Chairman.

My name is Rebecca Davis and I am the chairman of the legislative committee of the Association of Organ Procurement Organizations. I am also the president of LifeGift Organ Donation Center, which is part of the Texas Medical Center in Houston, Tex.

I am especially happy to be here today, because my Congressman, Michael Andrews, is a member of this subcommittee and has been a strong proponent of managed competition, and he has also provided invaluable assistance to the Texas Medical Center over the years.

I would like for my whole statement to be printed in the record. I am here on behalf of the Association of Organ Procurement Organizations or OPO's, as we are called. There are 57 members of our organization, which is the majority of OPO's in the United States. OPO's are the providers of organs for transplantation, and our mission as a national organization is to be an advocate of OPO's and to support those activities which will increase the availability of organs for transplant.

Our members have a distinct interest in these proceedings here today, as the inclusion or exclusion of transplantation will have a direct impact on the continued provision of organ transplantation and on the availability of organs.

We are seeking an express statement of coverage for extrarenal transplantation in the standard health care package. Extrarenal transplants include heart, liver, lung and pancreas transplants. We applaud the decision to continue coverage of kidney transplants under the ESRD provisions of Medicare. Eighty-nine percent of all kidney transplants will therefore be covered under Medicare.

The legislature and the Government have recognized that kidney transplantation is very cost-effective. In fact, kidney transplantation is one-third less expensive than the alternative treatment, which is dialysis, and transplantation provides a significantly better quality of life.

However, for many patients who are waiting for livers and hearts, there is no alternative treatment which will sustain their lives. We are concerned that the high profile of transplantation and its costs will make it a target for health care reform. Extrarenal transplantation provides a significant benefit to our patients, providing 1, 5 or more years of extended life at a cost which is comparable to the cost of treatment for other types of diseases and injuries that frequently have a lesser rate of success.

There are many examples that I can provide for you, including cancer care and dialysis care. But perhaps the most dramatic example is that of the care for AIDS patients. The cost for the care of patients with HIV or AIDS for the United States for 1 year is

an amazing \$10.5 billion. The cost to care for one patient for 1 year who has fullblown AIDS is \$102,000. Unfortunately, all the care that money will buy will not buy those patients more than an additional 500 days of life.

This is not to say that AIDS or cancer care should not be a covered benefit, but it is to say that coverage decisions must be consistent and they must be just and they must weigh the costs and the benefits. If extrarenal transplantation is not expressly covered, problems will arise due to a lack of a clear direction.

An AHP that is in California may cover transplantation. Whereas, an AHP in Florida may not. A patient who is waiting for a heart transplant in Houston may be covered for this service. Whereas, a patient who lives in Dallas may not. Therefore, we will have discrimination based on geography alone. This is contrary to the Federal policy which requires currently that there be equity of access to organs in the United States.

Additionally, failure to include coverage of extrarenal transplantation will discourage organ donation. If we create a two-tier system in transplantation, where the rich and other favored groups are able to have a transplant and others are not, then the public, perceiving that the access to organs is not fair, will not donate and the number of organs that are available will decline.

I would like to point out that this decline in the number of organs will not only cost patients their lives, but will also increase the cost of dialysis care to the Federal Government, due to the kidney transplants that will not be available.

The government has made a significant commitment to transplantation, with \$5 billion being committed in 1993 for research and programs supporting transplant. Accordingly, the public and the Federal Government have a vested interest in continuation of transplantation. Again, we are here to request an express statement of coverage for extrarenal transplant in the standard package.

I thank you and I will be happy to answer any questions.

[The prepared statement follows:]



**STATEMENT OF REBECCA J. DAVIS, PRESIDENT, LIFEGIFT ORGAN  
DONATION CENTER, TEXAS MEDICAL CENTER, HOUSTON, TEX., ON  
BEHALF OF ASSOCIATION OF ORGAN PROCUREMENT ORGANIZATIONS**

Good morning, Mr. Chairman and members of the Committee. My name is Rebecca Davis and I am the Chairman of the Legislative Committee of the Association of Organ Procurement Organizations. I am also the President of LifeGift Organ Donation Center, which is part of the Texas Medical Center in Houston, Texas. I am particularly happy to be here because my Congressman, Mike Andrews, is a member of this Subcommittee and has been a strong proponent of managed competition and provided invaluable assistance to the Texas Medical Center. I am speaking to you today on behalf of the Association of Organ Procurement Organizations, a trade association of 57 federally designated organ procurement organizations. APOPO's mission is to represent and serve organ procurement organizations through advocacy, support and development of activities that will maximize the availability of organs and tissues, and enhance the quality, effectiveness and integrity of the donation process.

The inclusion or exclusion of transplant costs from a standard health benefits package will have a direct impact on the continued provision of life-saving organ transplants as well as the supply of organs for transplantation. Accordingly, our members have a distinct interest in the outcome of these hearings and the bill ultimately enacted by the Congress.

We understand that the Medicare program, and thus payments for end-stage renal disease (ESRD), kidney transplantation and select heart and liver transplants, would continue intact under health care reform. Eighty-nine (89) percent of all kidney transplant procedures, and seven percent of heart and liver transplant procedures are currently covered by Medicare.<sup>1</sup> We recognize, however, that a growing number of ESRD patients are not eligible for the Medicare benefit. The federal government has established the cost effectiveness of kidney transplantation as compared to dialysis for treatment of end-stage renal disease. It is estimated that health care costs of patients with a functioning kidney transplant are approximately one-third of the cost of dialysis which is the only available alternative treatment.<sup>2</sup> Furthermore, the quality of life provided through kidney transplantation is significantly better than dependency on dialysis. We applaud the decision to retain payment of kidney and certain other transplants through the Medicare program.

The issue of extra-renal (heart, liver, and lung) transplantation is equally if not more critical due to the lack of alternative therapies to sustain the lives of patients with end-stage organ failure. We are concerned that the high profile and costs of these transplants will make them an easy target for health care reform. It is inappropriate to focus on the costs of transplantation without also examining its benefits. There are two important points to consider. First, the costs of treating a patient with end-stage organ failure is not dissimilar to the cost of the transplant. Unfortunately, our ability to provide transplants is limited by the availability of organs. If more organs were available in a timely fashion, the total cost of care for these patients would decrease. Second, the long-term costs of transplantation may actually be less than the costs associated with other therapies and treatments which are currently unquestioned.

According to the National Cooperative Transplant Study, studies are available which indicate that the costs of treating certain cancers can exceed \$30,000 annually and be required over

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<sup>1</sup>Evans, R.W. Executive Summary: The National Cooperative Transplantation Study. (BHARC-100-91-020) Seattle WA: Battelle-Seattle Research Center, June 1991.

<sup>2</sup>Evans, Roger W. A catastrophic disease perspective on organ transplantation. In: Ginzber E, ed. Medicine and Society: Clinical Decisions and Societal Values. Boulder, Co: Westview Press, 1987: 6195.



several years, frequently with less successful results, in terms of quality life years, than transplantation. Accordingly, on a comparative basis, the costs of managing cancer often exceed the costs of transplantation (at \$23,500 per year per case), to a lesser result. Other costly, yet accepted treatments include total parenteral nutrition (\$110,000 per year per case) and maintenance hemodialysis (\$25,000 per year per case). Treatment of 60% burn patients may exceed \$100,000 per case and the examples continue.<sup>3</sup>

Perhaps the most compelling testimony considers the treatment of AIDS patients. The cost to treat patients infected with the HIV virus is a remarkable \$10.5 billion per year, an average of \$102,000 per case for persons with AIDS. Unfortunately, all the care that money will buy will only provide these patients with AIDS an average life expectancy of 500 days. In contrast, the total expenditures for transplantation is estimated to be \$1.5 billion (at an average cost per case of \$40,000 to \$150,000) and will provide an average life expectancy of greater than 5 years of life to those fortunate enough to receive a scarce organ.

According to Evans, "In the past we didn't have the means to sustain life in the face of death to the extent we have today....Today, we have the technology and must choose when to and when not to use it. In the process, some lives will be deemed more valuable or worthy than others."<sup>4</sup> Health care policy for coverage of injury and disease must be consistent and just. An analysis of cost and benefits must be utilized in making such critical decisions. Based upon evidence presented herein regarding the costs and benefits of transplantation, we urge your consideration of coverage of extra-renal transplantation in the standard health care benefit package. We also ask that you include within the standard benefit package kidney transplantation for patients for whom it is not currently a Medicare entitlement or amend the Medicare statute to expand its coverage to include this group of patients.

The issue of organ donation is inextricably intertwined with continued coverage of transplantation. Organ donation is currently funded through the Medicare program for kidney transplants, and through acquisition fees for extra-renal transplants. Investments in organ donation are sound and should be encouraged. The more kidneys that are donated, the more money that is saved by the government and private insurers through reduction in dialysis costs. Additionally, if more extra-renal organs were available, costs for lengthy hospital stays and treatments pre-transplant could be avoided or reduced. Decreases in funding for organ donation programs will result in cut-backs in public education and training of health care professionals, and will inevitably decrease the supply of organs. The downward spiral created by such action will, in turn, increase the costs of treatment for end-stage organ disease: thus, a dollar will be spent in return for saving pennies.

An additional consideration for organ donation is the impact that excluding extra-renal organ transplants from the standard benefit package would have on the total organ supply (including kidneys). Organ donation depends heavily on public trust. If the public perceives that organ allocation is unfair, or that transplants are available only to the rich, or some other favored

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<sup>3</sup>The National Cooperative Transplantation Study: Final Report, Chapter 13.

<sup>4</sup>Evans, Roger W. A cost-outcome analysis of retransplantation: the need for accountability. Transplantation Reviews, in press.

<sup>5</sup>Evans, Roger W. A catastrophic disease perspective on organ transplantation. In: Ginzberg E., Ed. Medicine and Society: Clinical Decisions and Societal Values. Boulder, CO: Westview Press, 1987: 61-95.

group, organ donation will decrease substantially. It will not matter that kidney transplants are a covered service, and will, in fact, potentially disproportionately disadvantage minorities due to the higher incidence of hypertension and renal disease in blacks. Educating the public as to this distinction will not be possible, and kidneys, as well as hearts and livers, will become scarcer resources.

The federal government has a substantial interest in ensuring that organ transplants are included in the standard health care benefits package. The government has expended billions of dollars for health care, biomedical research, grants and programs in the transplant area. In FY 1993 alone, the federal budget included \$1.2 billion to the National Heart, Lung and Blood Institute and \$680 million to the National Diabetes, Digestive and Kidney Institute, a substantial portion of which is allocated to organ transplant research. In addition, the Public Health Service received \$2.768 million to support a scientific registry of organ transplant recipients, the National Organ Procurement and Transplantation Network, which matches organ donors with potential recipients, and for grants and contracts to improve organ donations. This does not include the millions of dollars that have been spent by Medicare to pay for the care and treatment of transplant patients. The federal government has demonstrated a strong commitment to promote organ transplants and clearly has a vested interest in the continued coverage of these procedures.

The viability of the extra-renal transplant industry will be in jeopardy if organ transplants are not expressly covered in the benefits package. An example of the ambiguity and inequity that can result from the failure to specifically address transplants is demonstrated by the proposal of the Jackson Hole Group for designing the Initial Uniform Effective Health Benefit Plan (March 1993). In its proposal, extra-renal transplants are neither expressly included nor excluded from coverage. The list of exclusions contains a catch-all provision for specific conditions or circumstances which are determined by the Health Standards Board or accountable health plans (AHPs) to have "no net benefit." This type of provision gives broad discretion to AHPs to assess the benefit of organ transplants on a case-by-case basis and will create great variance across the country with respect to the coverage of transplants. For example, an AHP in Texas may decide that transplants will be covered, while an AHP in California will not. This discrepancy can even occur within a single state or within the same OPO service area, as, for example, an AHP in Houston may cover transplants, while an AHP in Ft. Worth may not. This will create an untenable situation for the entire nationwide organ procurement network because each OPO will be operating under a different set of rules.

More importantly, however, this will be directly contrary to the federal mandate requiring equitable treatment of transplant patients. The National Organ Transplant Act, 42 U.S.C. § 273, *et. seq.*, requires that OPOs allocate organs equitably among transplant patients. The current flexible system within which OPOs operate today has been designed to satisfy this criteria. A system which enables each AHP to decide whether to cover transplants is antithetical in both philosophy and language to the federal statute. In order to ensure that transplant patients are treated equitably throughout the United States, we need clear guidance from the Congress as to how organ transplants will be treated in the standard benefits package. There must be a clear directive in the health care reform legislation with respect to the coverage of organ transplants. This is far too critical an issue to be left to the discretion of AHPs.

The issues involved in organ donation and transplantation are complex and I thank you for giving attention and time to this small but vital part of the total health care picture. I would like to

close by citing noted ethicist Dr. Edmund Pellegrino of Georgetown University, who has stated that

"Technology by itself is morally blind. It devises means, solves problems, and supplies techniques, but it cannot discern how its means, solutions, and techniques can best be used for humane ends. Economics, too, is morally blind -- a fact we must not forget in today's enthusiasm for economic solutions to some of the pressing problems of resource allocation in medicine. Economics can provide the means for managing resource allocation, but it cannot define the values and the purposes that should guide those allocations. In a morally just society, the guiding principles are moral in nature, not biological, sociological, or economic."<sup>6</sup>

We ask the Committee today to look to the morality and ethics of funding organ transplantation, as well as costs. Thank you for the opportunity to present our views. I would be pleased to respond to any questions.

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<sup>6</sup>Pellegrino, Edmund D. Medicine and the liberal arts, the bridge of ethics. Alabama Journal of Medical Sciences. 22(3): 13-16, 1985.



Mr. KLECZKA. Thank you, Ms. Davis.

We have one more panelist who has been with us for a very long time who hasn't had a chance to say anything. Joel, would you like to say a couple of words while you are here?

#### STATEMENT OF JOEL MYERBERG, BALTIMORE, MD.

Mr. MYERBERG. Only that by using the medical equipment that I use, I have been allowed to participate on 18 different boards and as a part of the Governor of Maryland's executive staff. If this medical equipment that I use is taken away, then I can no longer function in the community and, of course, I would wind up in a nursing home.

One of the pieces of equipment—there are so many pieces I use, this wheelchair here allows me to sit for many more hours at board meetings and all of that. As a volunteer, I sit and I work with disability rights, and these rights are important to so many people.

I work in the municipal health service program as a volunteer, a program that this subcommittee oversees, and it is awfully important to so many consumers like myself. I speak now for so many low-income people in this country. As you have been hearing from professionals all day, I can agree with so much of what they are saying, but the consumers are the ones that use all this equipment, they use the hospice services, they use physical equipment, the occupational therapy. That is why I say, no matter what you decide, whether it is Congress or if it is a public board that makes the decisions—

Mr. KLECZKA. That is my next question.

Mr. MYERBERG. There has got to be some input in some way by the consumers of these services. There are many people like me out there who want to participate, people with credentials and education.

I would not want to see Congress set boards up with just anybody on them. I certainly want people of some stature in the communities, but there have got to be nonprofessionals that use the equipment, use all of these multiple services. Without these services, it just won't work.

One of the pieces of home medical equipment I use is the nebulizer. The nebulizer blows a mist or spray into my lungs. This menial sounding piece of equipment, which is as big as a bread box, allows me to be here today and speak to you. Without this piece of equipment, I would be somewhere in a hospital paying thousands of dollars a month or a nursing home at \$120 a day, instead of in the community where the cost to the country is minimal. I believe it cost \$36 a day to keep me at home which is a lot cheaper.

Of course, by keeping me at home, I am able to attend hearings like this and have an impact on people like you. So maybe in your consideration and deliberations, you can see the wisdom of including the disabled users of equipment, the users of these services in the final decision.

Mr. KLECZKA. Thank you very much, Joel.

Mr. MYERBERG. Thank you.

Mr. KLECZKA. You started answering the question and I am going to ask the balance of the panel—who should actually decide which basic services are going to be in the plan? Should it be Con-



gress or some type of a national health board? What would the various panelists prefer or recommend us to do on that score?

Mr. Mahoney.

Mr. MAHONEY. The National Hospice Organization doesn't have a specific position on this particular issue. I guess I would say that I am certain there are certain benefit that could be derived from having a national board. However, I think everybody involved, providers and consumers alike, would be concerned about the makeup of that board, and certainly the accountability of the board.

I guess the other thing that I would probably suggest is that if the work of that board did not meet the expectations of the American public, I could only think that it would be the Congress that the American public would hold responsible for that. I guess that does not really answer your question, but I think that when it comes right down to it, the Congress is going to be ultimately responsible, but I think they should probably be taking the lead in that area.

Mr. KLECZKA. Thank you.

Mr. Thatcher.

Mr. THATCHER. Yes, Mr. Chairman, I think I agree with Mr. Mahoney. Congress is obviously ultimately accountable, and that is fairly simple to see. But I think if you think about it, there are a number of very complex and interrelated issues here that health experts—you said earlier that you might not all be able to be health experts—health experts can't be experts in taxation, nor experts in labor policy, nor experts in antitrust policy, and the many other issues that are going to be generated by the discussions of this benefits package. So I don't think you can hope to delegate these things to a health board and have them bring back to you an initial package that you will be able to move through your body quickly.

I want to emphasize that I think you need to set up a process that will facilitate this decisionmaking and do so quickly. The world is going on out there, folks, and things are changing. As you well know, States are implementing policies and programs, moving in a myriad of different directions, and that makes it extremely difficult on those of us attempting to serve the public out there. When we have to deal with 10, 15, 20 different State reform programs, we begin to generate policies, procedures, paperwork and systems that become redundant, complex and costly, so we really do need you to move quickly, and I would encourage you to set up a process that enables you to do that.

Mr. KLECZKA. Thank you.

Mr. BAINUM. Very briefly, because the design of the benefits package fundamentally drives the cost of health care reform, and because the Congress has to come up with ways to fund the cost of health care reform, I think that Congress would want to have great input and sign off on the design of the benefits package.

Mr. KLECZKA. Ms. Lawe.

Ms. LAWE. I agree. Our organization believes that the responsibility should rest with Congress, and would actually have a concern about added bureaucracy or red tape in terms of delivery of health care services, if there were a separate board.

Mr. KLECZKA. Ms. Davis.

Ms. DAVIS. Again, my organization also does not have a position on this. I would echo the sentiments of my colleagues that Congress will be ultimately responsible. There has been a lot of effort and work that has gone into health care reform thus far.

There was an interesting article in the Wall Street Journal this morning that talks about this process. And we have been asking the question where does high-technology fit in health care reform, and our voices are going out there and we are not getting any feedback, and so we don't have a very good idea of where the task force or a national board would go in this particular area.

Mr. KLECZKA. Thank you.

Mr. Kirson.

Mr. KIRSON. I just feel that it is too important of a decision to be left up to anyone other than Congress, and it probably needs to start right here with this committee here who are health care experts in the country. So it is our position, the position of the National Association of Medical Equipment Suppliers that this should be a congressional decision.

Mr. KLECZKA. Mr. Williams.

Mr. WILLIAMS. I agree with the panel. The home medical equipment industry has probably smarted as much as anybody, by the failures of delegation in the past. If you want to achieve some sort of uniformity or continuity across the country, Congress is going to have to clearly articulate these are the benefits, these are the covered services, these are the limitations, and then work within them.

We can no longer afford to delegate to a board that is not accountable or whose actions can then be interpreted by the courts to see whether or not they are in concert with the wishes of the Congress. The Congress itself is going to have to establish the standards and then empower agencies to work within them, but don't leave it up to them.

The best example of the failure of this system that I heard was recently a senior policy setter at the Health Care Finance Agency, this is last November, in a public meeting, when we were talking about home care and home care equipment, and we were talking about the needs to have some Medicare coverage for certain bath aids, this individual said at a public meeting, and has repeated since, "You will never convince me that a bath is a medical necessity."

Now, when Congress delegates it to people like that, the authority that you would tell me that a bath is not a medical necessity, I would be scared. But you cannot delegate any of these decisions. You have to make them and make them so that they can withstand the test of time and can also stand the inevitable test of the courts.

Mr. KLECZKA. Thank you very much.

Congressman McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I just want to ask a couple questions that actually come off the question of home health care. Mr. Thatcher, you are involved in home healthcare and I wonder what kind of data is available to show its cost-effectiveness. Intuitively, one might suggest that it does, but I wonder what kind of data has actually been gathered.



Mr. THATCHER. I think historically, Mr. McDermott, if you look at companies like ours and others, our procedures and systems have not been set up to gather the types of outcome-related data that medical researchers might like to see, so in that sense, there may be insufficient data as to what some people might like to see.

On another perspective, I think you have heard from a number of people today, myself included, regarding what I think are some very persuasive examples that enable one to make some very sound judgments. I think they are quite compelling. You heard earlier from Ms. Raphael of the New York Visiting Nurse Service, about how their organization had saved. I believe, Mr. McDermott, it was \$5,000 per patient relative to AIDS patients.

Our own organization has data and we have presented some of that today, our ability to save a California HMO half a million dollars in 6 months, our ability to save approximately \$3,000 per procedure on joint replacements. I think these are very compelling arguments. So that while there may not be valid statistical data in a research sense that medical researchers might like to see, particularly related to outcomes, I think inferences can be drawn from innovations really that are quite recent in the field.

As managed care has put more pressure on us in recent years, we have begun to track these things and we have begun to do more innovative things related to cost savings. I think it is compelling and I think it is relatively conclusive that these things are having a tremendous effect. It seems to me that they are persuasive for the use of home care and the cost-effectiveness thereof.

There is an old saying that the greatest enemy to a good plan is a perfect plan. I think that is a little bit of what we are seeing here. There may not be conclusive historical data, but there certainly is an awful lot of good current information.

Mr. McDERMOTT. Does anybody else want to comment?

Mr. KIRSON. I would like to answer that, also. I am Don Kirson, with the National Association of Medical Equipment Suppliers, and I think in my written testimony you will find there is some information about a Lewin study that was done a few years ago that took one diagnosis of a fractured hip and combined it with changing the treatment and involving home care, and there was a savings of \$575 million just on this one diagnosis alone.

I also have in front of me, I was just handed by our president, a home care digest put out by NAMES, and there are two charts in here that discuss how cost-effective home care is, and I would be glad to share that information with you.

One of them is a study done in Maryland on pediatric cases, and it showed that home care saved more than \$15,000 each month per patient, with \$3.1 million saved during a 34-month period. So here is the study and all the information is in here and I would be glad to leave it with you.

Mr. McDERMOTT. If you would give that to the committee clerk, I would appreciate it.

Mr. KIRSON. Absolutely.

The document has been retained in the committee files.]

Mr. McDERMOTT. Anybody else?

MR. MAHONEY. If it is OK, I would like to speak to hospice care revolving around that issue. Certainly, there is some data. There

is not as much as we would like to see, but clearly, within hospice care, it is the ability to substitute for hospital stays that is saving money. We do have some studies and I have testified about those earlier.

Within the HMO system, we are aware of the fact that Kaiser did a study where they showed savings of over \$1,400 within their own HMO system. So I think there is certain amount of data out there and we would certainly like to see more.

Mr. McDERMOTT. Thank you.

Mr. KLECZKA. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I cannot let this opportunity go by. It is rare that there is a panel that appears before the Ways and means Committee where I have two constituents on the panel and a third, a former colleague of mine in the Maryland State Legislature.

I would like to tell the committee that Joel Myerberg is an inspiration to all of us as to the importance of making sure that we provide adequate services to the people of our community. Joel has done a tremendous job in rehabilitating himself and becoming a very productive member of our society, and I really congratulate him.

I have been to his home, I have seen what he has been able to do, and I tell the members of the committee that he is almost always right on the issues and he is an extremely effective lobbyist, so I would urge you all to agree with him sooner, rather than later, to avoid all the phone calls and letters that you will be receiving otherwise.

We very much appreciate your appearance here today. It puts a face on a lot of the statistics that we hear so we can see firsthand how programs can help people and can make our society a better society. Joel, I want to thank you personally for being here today.

Don Kirson is also a constituent of mine and has provided national leadership for the equipment suppliers. Don has worked very well in his leadership capacity with the Congress on constructive legislation to improve the quality of service provided in this Nation, and I am very proud to be able to call Don not only a constituent, but a friend.

And Stewart Bainum is a former State Senator. I got to know him very well when he was a member of the House of Delegates and I was a member of the Maryland House of Delegates. He is always known for his leadership on tax issues, on fairness issues, as a progressive member of the Maryland State Legislature.

Stewart, your subacute care program is a model for the Nation and I fully hope that we can follow the leadership that you have been able to establish in health care in developing less costly alternatives for treating people in our health care system.

Mr. Chairman, I think that is the real message of the panel that we have before us, and that is as we look for ways of cutting cost, we are not going to save any money by eliminating the types of services that are represented by the people before us right now. In fact, we will save money by expanding these services.

What concerns me is that in some of our efforts to cut cost, we look at reducing the benefits that are available in a program for the immediate dollar savings, knowing full well that, in the long



term, it is going to be more costly for the people of this country and for our health care system generally.

I don't have any questions, but I wanted to thank all of the people on this panel for their patience—I know it has been a long day—for their patience of coming here and telling us your story. I certainly hope that the final package that we bring before the American people on health care reform will include the services that are represented before us today.

Thank you.

Mr. KLECZKA. Thank you, Mr. Cardin, for your comments and I join with you in thanking this panel not only for their testimony, but also for their patience. Being last is not always the best, but it is not always the worst, either.

Thank. Joel, I also thank you, also.

We have a prepared statement of a witness who was unable to stay and we will make it a part of the record. It is by Lisa Kory, president of the North American Transplant Coordinators' Organization.

[The prepared statement follows:]

## STATEMENT OF LISA R. KORY, PRESIDENT, NORTH AMERICAN TRANSPLANT COORDINATORS' ORGANIZATION

Good Afternoon, Mr. Chairman, committee members and staff. My name is Lisa Kory. I am President of the North American Transplant Coordinators' Organization and a registered professional nurse currently employed by the California Transplant Donor Network in San Francisco, California.

The North American Transplant Coordinators' Organization, NATCO, represents approximately 1600 organ procurement and clinical transplant coordinators throughout the United States. Our organization has devoted its efforts to developing and advancing the profession through education and networking opportunities and acknowledging the contributions of donors, recipients and their families. NATCO welcomes the opportunity to comment on the comprehensive benefit package being considered as part of the health care reform model and the status of organ donation and transplantation within the United States. In particular, as transplant services are now routinely available throughout the U.S., it is essential to assure continuation of these medical benefits in any newly reformed model.

There are two key components currently covered by Medicare, Medicaid and most private insurers that must not be omitted: coverage of organ and tissue transplantation (inclusive of organ acquisition costs) and immunosuppressive drugs.

### TRANSPLANTATION SERVICES

First performed clinically in 1953, organ transplantation is no longer considered an experimental procedure. Medical and surgical techniques and immunosuppressive drugs have contributed to continued success rates with transplantation. The one year survival for specific transplant procedures is as follows: 92% for kidneys, 79% for hearts, 76% for livers, 59% for heart/lung, and 89% for pancreas (Evans, R. 1991). Currently there are 240 kidney transplant programs in the U.S., 159 heart transplant programs, 109 liver programs, 87 heart/lung programs and 103 pancreas transplant programs (UNOS, 1993).

Although limited by the supply of available organs and tissues, transplantation has been highly successful in saving lives and in the case of kidney transplantation, providing a less costly and more effective treatment option. An average organ recipient lives more than eight years experiencing significantly increased quality of life. Three years after kidney transplantation, the patients with transplants represent a net savings to the Medicare program. The costs of maintaining patients with functioning kidney transplants are only one third of those for patients on dialysis and the quality of life is far improved. Kidney transplantation therefore, presents the best clinical and economic outcomes for patients with end stage renal disease and will have the effect of slowing the rate of increase of overall health care costs. (Eggers, P. 1990)

Government financing for transplantation began with the passage of the Social Security amendments of 1972 whereby patients with end stage renal disease became entitled to Medicare coverage based on their disease condition. Coverage included both dialysis therapy and transplantation. Today, Medicare coverage extends (for the aged and disabled) to bone marrow transplantation, corneas, heart, and liver transplants as well as kidneys. Currently, coverage of heart and liver transplants are limited to federally designated medial centers.

Medicaid coverage varies from state to state. All 50 states and the District of Columbia pay for some transplantation procedures. Bone marrow, cornea, kidney and liver transplants are almost universal. Heart transplants are available in most states (40), but coverage remains limited for heart/lung, lung and pancreas transplants. In the case of liver transplants, eleven states limit the procedure to children only (under the age of 18). Ten states have set payment limits or caps on organ transplant

surgery. All states offer some payment for immunosuppressive drugs.

Most private insurers cover bone marrow, cornea, heart, kidney and liver transplants. However, some insurers do not pay for heart/lung, lung or pancreas transplants. Even if a patient has Medicare, Medicaid or private insurance, most policies do not cover all costs associated with the procedure, particularly outpatient costs. Many private insurers will not cover the costs associated with organ recovery. Thus these patients often face substantial medical bills. To some degree private insurers have controlled costs by negotiating contracts with certain "centers of excellence"; transplant centers selected for experience and outcomes. Contracts with these centers are linked to referral patterns resulting in volume discounts.

Unfortunately, some believe that transplantation remains a high cost procedure that demands reconsideration of how government and private resources should be spent. However, hospitalizations and increased medical care required by patients suffering from end stage organ failure is vastly more expensive than early transplantation. In 1990, 2206 patients with end stage organ failure who were on a waiting list died for the lack of life saving organs. (Anneberg Report, 1991) Medical costs associated with the last stages of life can be astronomical and easily exceed even the most costly surgical intervention.

Coverage by federal programs as well as private insurers should extend to those transplant procedures that have proven successful. Additionally, adequate reimbursement should be provided to assure long term success. Federal mandates require equitable treatment of transplant patients. As current discussions regarding a newly designed health care system include the formation of accountable health plans (AHPs) and negotiations between providers and insurers, it is imperative that coverage decisions are not left to the discretion of the individual AHPs. This would result in inequitable access to transplant services.

NATCO believes that coverage of these life savings procedures must continue under any new health care reform package. NATCO endorses quality treatment for all patients with end-stage organ failure and encourages the dissemination of information to all consumers to allow informed decisions to be made in regard to the risks and benefits of all therapies. Patients must remain active participants in the decision making process regarding their own medical care.

In 1990, the amendments to the National Organ Transplant Act, authorized public release of transplant-center specific survival data. This report, developed by HHS and UNOS, provides information on specific hospital patient and graft survival rates for kidney, heart, lung, liver and pancreas transplants. The results of this comprehensive study offer pertinent information to patients and their families to assist in the selection of organ transplant centers and is similar to the hospital mortality data released by the Health Care Financing Administration (HCFA). In addition, this report analyzed long term success rates for repeated transplant procedures and found that survival rates diminished markedly with the second and third transplant.

#### **IMMUNOSUPPRESSIVE THERAPY**

It must be remembered that organ transplantation is not a cure, but controls organ failure. Transplant patients face a set of predictable problems. They remain at risk of chronic rejection of the transplanted organ and are required to take medications to prevent rejection for the remainder of their life. The medications that prevent rejection, immunosuppressive drugs, also place transplant patients at risk of communicable diseases. The costs of immunosuppressive therapy remain considerably less than treatment of complications associated with end stage organ failure or the need for repeated transplantation.

Given the marked differences in survival rates in second and third transplants, it is essential that patients receive necessary



medication that prevent rejection of transplanted organs. Many professionals are convinced that a major cause of noncompliance in the transplant patient is the cost of long term immunosuppressive drug therapy. Beginning in 1986, Congress granted special exception to Medicare coverage of outpatient immunosuppressive prescription drugs, ensuring that Medicare transplant patients had at least initial access to these costly drugs. Medicare currently pays for immunosuppressive drugs the first year post-operatively, which is considered the most expensive period. However, costs for these drugs still range from \$2500 - 4000 annually during subsequent years. The extent that patients are at risk is dependent on whether patients have additional third party coverage.

A survey conducted in 1990 by the American Society of Transplant Surgeons (ASTS) painfully documented that a number of Medicare beneficiaries have trouble paying for drugs post transplant. State funds may not be available and too often Medicaid programs are limited.

The Medicare Catastrophic Coverage Act would have extended coverage for these much needed drugs providing the patients remained eligible for Medicare. Repeal of this act raised serious concern about the lack of adequate coverage. In 1990, the Senate Finance Committee requested the Office of Technology Assessment (OTA) to examine current Medicare immunosuppressive drug coverage and payment policies for outpatient immunosuppressive drug therapy. OTA found that several factors can influence drug costs: development of new pharmaceutical products, expiration of drug patents (such as cyclosporine in 1995) and increased patient compliance whereby extended coverage could result in fewer failures and hospitalizations.

The OTA report stated that "at least some of the costs associated with organ rejection, i.e. repeated hospitalization, return to dialysis, graft failure and other complications associated with rejection would be reduced with expanded Medicare coverage."

#### LONG TERM DISABILITY VS EMPLOYMENT

Although many patient's quality of life improves post transplant, enabling them to return to work, most transplant recipients opt to remain on Medicare as they qualify for Medicare disability coverage. Patients choose not to seek employment after successful transplants for fear of not qualifying for private health insurance. Retaining medical benefits is a high priority for these patients and their families. Studies conducted by Roger Evans, PhD, a social scientist formerly of the Battelle Human Affairs Research Center, found that patients although able to work are often not considered for positions because of employer concerns of future health problems and insurance costs. The employment record of transplanted patients is similar to other patients surviving heart attacks and/ or cancer. (Evans, R. 1990)

Loss of private insurance due to job change over, limited coverage based on pre-existing health conditions and the high cost of insurance premiums are problems routinely faced by patients with chronic disease conditions. Many can not obtain much needed health insurance. These problems must be addressed in any health reform package, especially if we are to achieve the greatest benefit from transplantation - enabling patients to return to work and assume productive lives in society.

An Anneberg Washington Program conference concluded that the cost effectiveness and appropriate coverage of transplantation must be evaluated in regard to other life saving procedures. "The cost of transplantation is ultimately borne by all of us through increased public expenditures (taxes) and increases in private insurance premiums."

Thank you for the opportunity to offer NATCO's comments. I welcome any questions you may have.



Mr. KLECZKA. Thank you all again.

The subcommittee is adjourned.

[Whereupon, at 3:29 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

## **STATEMENT OF CHIEF MASTER SERGEANT BOB MILLER, USAF, RETIRED, AIR FORCE SERGEANTS ASSOCIATION**

Mister Chairman and distinguished members of the committee, I greatly appreciate having the opportunity to present views on behalf of the 167,000 members of the Air Force Sergeants Association (AFSA) and all enlisted personnel of the Air Force — active duty, Guard, Reserve, retired, veterans, and their families.

As the Clinton administration and Congress address National Health Care reform, we must ensure that the Military Health Services System (MHSS), backed up by the Veterans Affairs hospital system, is not degraded in the process.

The MHSS is essential to readiness, national disaster missions and mobilization. These missions cannot be filled by reserve component units or civilian facilities. Further, to recruit, train and retain a viable uniformed medical corps, we must have a full graduate medical education program for a wide range of patients, from pediatrics to geriatrics.

We would like to provide some background and history regarding the MHSS from the perspective of the active duty, retired, Reserve and Guard personnel, and their families and survivors, who use the MHSS and why they believe they have been promised free lifetime medical care. That promise is contained in various laws and traditions, and dates back more than 200 years.

### **Promise of Health Care for Life**

Prior to the early 1950s, the promise to provide military medical care was not questioned because throughout their military careers and in retirement, medical care was provided in military facilities for personnel who could use those facilities. There was not a huge number of retirees during this period and they could be accommodated. At that time and for years afterward, a lifetime of medical care appeared plausible since the military medical system had, in fact, kept these promises. Thus, such promises seemed reasonable when noncommissioned officers, first sergeants and commanders promised potential recruits and candidates for re-enlistment, who were needed to man the large military force required to fight the Cold War, that lifetime medical care would be available for them.

### **Codifying Access to the MHSS**

In 1956, when there were only approximately 6.4 million beneficiaries of the Defense Department's medical system, Congress made space-available medical care in military treatment facilities (MTFs) an entitlement for active duty dependents. Retirees and their dependents were also authorized space-available care without an entitlement to it. Also in 1956, Congress concluded that the direct care medical system was inadequate to care for the dependents of active duty personnel and enacted legislation authorizing the Defense Department to contract with private sources to supplement the inadequate in-house care for dependents of active duty members who, due to travel distances or other reasons, could not use the military treat-

ment facilities. This was the forerunner of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

### The CHAMPUS Alternatives

The CHAMPUS program was enacted because the increasing number of retirees and dependents of the large active duty force necessary to deter the Soviet Union and communism around the world made it increasingly difficult to provide such care without major increases in the military medical staff. Ten years later (1966), retired members under age 65 (and their dependents) became eligible for CHAMPUS, because when Congress enacted the Medicare system in 1966 (covering retirees aged 65 and older), retirees under age 65 (and dependents) were the only group of beneficiaries not covered by any medical insurance system. This action, in fact, was an after-the-fact admission that the Defense Department had a major responsibility for these beneficiaries and was honor bound by their recruiting and retention promises.

CHAMPUS required the Defense Department to pay 80 percent of allowable medical costs for active duty dependents and 75 percent of the cost for retirees and their dependents. The current annual deductibles are \$150 per person, up to \$300 per family. The beneficiaries are required to pay the remaining balance of the cost of the medical care they receive.

Today, according to Defense officials, there are about 9.5 million CHAMPUS beneficiaries, with military retirees and their dependents comprising over 50 percent of this group. This large increase in retirees and dependents is obviously due to the large military force needed to fight WW II, the subsequent hot wars and the 45-year Cold War. To meet the huge active force requirements after the Korean War, the Defense Department used aggressive recruiting and retention programs, especially after the military draft system was abolished. To maintain this large, all-volunteer military force, commanders and recruiting/retention personnel promised (in exchange for 20 or 30 years of dedicated and devoted service) retirement security, with inflation-protected retirement pay, lifetime medical care, and lifetime use of other retiree support facilities such as post exchanges and commissaries.

The authorization for continued military medical care on a space-available basis with CHAMPUS as a backup was, therefore, established in law. As our armed forces are reduced and military installations and medical treatment facilities are closed, space-available medical care is becoming even more scarce. One of the adverse side effects is age discrimination, even though current law provides for the treatment of space-available eligible beneficiaries without regard to age. In practice, age discrimination exists simply because it is in the financial interest of the Defense Department to conserve CHAMPUS funds by treating beneficiaries under 65 in-house and forcing Medicare-eligible beneficiaries to rely on the private sector where the Health Care Financing Administration picks up the expenses. Care for CHAMPUS-eligible beneficiaries in MTFs permits DOD to save the more costly expense of the for-profit private sector treatment of Defense Department beneficiaries, which is now about twice the cost of treatment obtained in military medical facilities.

### Employer Responsibility

Loss of CHAMPUS medical benefits at age 65, just when they need it most, is a major concern of military retirees. It is a great inequity that military retirees, their families and survivors are the only federal government retirees who lose their medical care entitlement at age 65. These military retirees, especially resent, and justifiably so, the fact that after earning what they thought was free lifetime medical care by serving 20 to 35 years of military duty, they are now being turned away from that care. A solution that will help mitigate age discrimination and give substance to the lifetime promise is discussed later.

We strongly believe that the Defense Department should not be permitted to drop all legal responsibility for the medical treatment of over-age-65 military retirees. Legislation is urgently needed to recognize the explicit and implied promises and provide a defined, lifetime benefit for military retirees and their families and survivors, regardless of age. In 1992, the 102nd Congress recognized the promise of lifetime medical care and acknowledged it in a "Sense of the Congress" resolution contained in Section 726, National Defense Authorization Act for Fiscal Year 1993 (Public Law 102-484).

### *"Sense of Congress" Resolution*

"It is the sense of Congress that-

(1) Members and former members of the Uniformed Services, and their dependents and survivors, should have access to health care under the health care delivery system of the Uniformed Services, regardless of the age or health care status of the person seeking the health care;

(2) Such health care delivery system should include a comprehensive managed care plan;

(3) The comprehensive managed care plan should involve medical personnel of the Uniformed Services (including reserve component personnel), civilian health care professionals of the executive agency of such Uniformed Services, contract health care personnel, and the Medicare system;

(4) The Secretary of Defense, the Secretary of Health and Human Services, and the Secretary of Transportation should continue to provide active duty personnel of the Uniformed Services with free care in medical treatment facilities of the Uniformed Services and to provide the other personnel referred to in paragraph (1) with health care at reasonable cost to the recipient of the care; and

(5) The Secretaries referred to in paragraph (4) should examine additional health care options for the personnel referred to in paragraph (1), including, in the case of persons eligible for Medicare under title XVII of the Social Security Act, options providing for-

(a) The reimbursement to the Department of Defense by the Secretary of Health and Human Services for health care services provided such personnel at medical treatment facilities of the Department of Defense; and



(b) The sharing of the payment of the cost of contract health care by the Department of Defense and the Department of Health and Human Services, with one such department being the primary payer of such costs and the other such department being the secondary payer of such costs."

### **Budget Cuts Severely Curtail Services**

We understand cuts in the Army Medical Budget for FY 94 will reduce buying power by more than \$437 million or nearly one-half billion dollars below the fiscal year 1993 level. Similar cuts are being considered in other services. There is no way that cuts of this size can be imposed without a severe curtailment of medical services.

These funding reductions follow deep cuts in military medical personnel to meet reduced service end-strength ceilings. While the services face a reduced enemy threat, the demands on the medical corps are not substantially reduced. However, medical personnel fall under the service end-strength ceilings and must also be reduced to meet the new troop strength levels. Arbitrary requirements such as this cause bad decisions. The system could be improved by removing medical personnel from service end-strength calculations. This would allow better management of the entire MHSS.

At military treatment facilities throughout the United States, including the Army's flagship hospital, Walter Reed Army Medical Center (WRAMC), thousands of military retirees are now being denied medical care. For example, at WRAMC there are 1,612 beneficiaries on a waiting list extending out 13 months for the Ophthalmology Clinic. The Optometry Clinic has 1,396 on the waiting list, representing a 36-month backlog. The General Medical Clinic has a backlog of 847 beneficiaries and the Audiology Clinic, 1,468. To suggest that the system can absorb further cuts in either personnel or funds is outrageous.

### **Concerns of Military Beneficiaries**

Military beneficiaries who are forced to rely on CHAMPUS for a great portion of their care are very concerned about cost and access to care through the Military Health Services System (MHSS), the quality of such care, the uncertainty of the "space-available" basis for care received in the medical treatment facilities (MTFs), the impact of base closures and the future of the MHSS in general. The following discussion addresses some of the specific concerns expressed by our members. It also includes other recommendations for improving the MHSS through initiatives to promote equity, cost savings and efficiencies.

### **Assignment to Remote Duty**

Health care coverage is not equitable for dependents of active duty members who are assigned to duty stations not served by military medical treatment facilities (e.g., recruiters, ROTC instructors, Coast Guard). These dependents are forced to rely on CHAMPUS with its attendant co-pays and deductibles. CHAMPUS is not accepted by all physicians, so the choice of

health care provider is often limited or the member must absorb higher out-of-pocket expenses because of balance billing. Conversely, dependents of active duty personnel assigned to bases with MTFs have the choice of free care at MTFs, if available, care through direct referral to civilian providers, or care through CHAMPUS.

**Recommendation:** Provide for 100% health care coverage for active duty families assigned to locations without access to MTFs through contracts with local providers, if possible. If such contracts are not possible, CHAMPUS co-payments and deductibles should be waived for these individuals. If dependents do not reside with the member or have elected not to participate in the program provided through contracts with local providers, then standard CHAMPUS co-pays and deductibles should apply.

### **Access to MTFs for Disabled Dependents**

Unmarried, disabled dependents over 23 who once again become dependent on the member for support are not eligible for space-available care in MTFs. This results in a significant disparity because space-available care in MTFs is provided to parents and parents-in-law who become dependent on the member for support. There are no compelling reasons why disabled dependent children should not be provided access to space-available care in MTFs to the same extent it is provided for dependent parents and parents-in-law.

**Recommendation:** Allow unmarried, disabled dependents over 23 who once again become dependent on the member for support to have access to care in MTFs on a "space-available" basis.

### **Penalty for Late Enrollment in Medicare Part B**

Retirees and their dependents who locate near a base frequently elect to waive enrollment in Medicare Part B because of reliance on an MTF. If a base and its MTF close, Medicare-eligible retirees must then rely on Medicare Part B for care by physicians and other providers. They then incur substantial financial penalties of 10 percent per year when they enroll in Medicare Part B.

**Recommendation:** Waive Medicare Part B late enrollment penalties for retirees residing near base closure sites.

### **Inadequate Catastrophic Protection**

The CHAMPUS Catastrophic Cap for retiree families (currently \$7,500) does not provide adequate catastrophic protection. Since the cap only applies to allowable costs, in many cases, families end up spending much more than \$7,500 per year in out-of-pocket costs. The CHAMPUS Catastrophic Cap for active duty families is only \$1,000 per year, and when they reach the retirement threshold, many are ill-prepared for the dramatic increase in liability and/or are ineligible for supplemental insurance coverage because of pre-existing illnesses or injuries. In this regard, military retirees have been victimized because of budgetary constraints. When the \$1,000 cap for active duty dependents was established, the House proposed a \$3,000

cap for retiree families. However, in conference with the Senate, the ceiling was raised to \$10,000 because of higher priorities, but with the assurance that a more reasonable cap was on the horizon. About a decade later, the FY 93 Defense Authorization Act reduced the cap to \$7,500.

**Recommendation:** Reduce CHAMPUS Catastrophic Cap for retirees and their dependents to \$3,000.

### **Medicare Providers Refuse CHAMPUS Assignment**

Many physicians who accept Medicare assignment (i.e., accept Medicare reimbursement amounts for treating Medicare-eligible individuals) will not accept CHAMPUS-eligible patients. Many of these physicians claim they can only handle one form of government reimbursement. The ulterior motive is that given the price controls on Medicare, they can recover some of their "lost profits" by charging the higher fees of private sector insurers and CHAMPUS. Physicians who accept one type of government-subsidized patient should not discriminate against beneficiaries of another government program such as CHAMPUS.

**Recommendation:** Require physicians who accept Medicare assignment to also accept CHAMPUS assignment.

### **Loss of CHAMPUS When Medicare-Eligible**

Military beneficiaries who are 65 years or older lose CHAMPUS benefits if they are eligible for Medicare. Because many Medicare supplemental plans have pre-existing medical condition clauses that preclude coverage for many older individuals, Medicare-eligible military beneficiaries are confronted with significant out-of-pocket costs. The financial burden is aggravated, because loss of CHAMPUS also means loss of prescription drug coverage, particularly for individuals not residing within commuting distance of military facilities. Another negative aspect associated with the loss of CHAMPUS is that Medicare does not provide coverage for individuals who travel or reside overseas.

**Recommendation:** Restore CHAMPUS as second payer to Medicare for Medicare-eligible individuals on a "coordination of benefits" basis. (CHAMPUS would be primary payer for individuals residing overseas who are not covered by Medicare.)

### **HCFA Reimbursement to MHSS Facilities**

The Health Care Financing Administration (HCFA) does not reimburse military MTFs or Uniformed Services Treatment Facilities (USTF) for care provided to Medicare-eligible retirees. Conversely, HCFA does reimburse civilian health care providers for care for Medicare-eligible individuals. Faced with severe fiscal constraints, Commanders of MTFs and Directors of USTFs currently have a strong economic incentive to deny care to Medicare-eligible retirees by turning away these beneficiaries. If HCFA were to reimburse MTFs or USTFs for care provided to Medicare-eligible retirees at a discounted rate (for less than reimbursement to civilian health care providers) and MTFs and USTFs were allowed to use these funds for expansion of services, a win-win situation for all would evolve. HCFA



would pay less for care provided to Medicare beneficiaries; military MTFs or USTFs would have more money coming in to increase services; and, beneficiaries would experience less out-of-pocket costs. Further, if DOD were allowed to include Medicare-eligible retirees in DOD managed care networks, HCFA would save even more. The Senate Armed Services Committee's (SASC) version of the FY 93 Defense Authorization Bill provided for a test of this reimbursement concept we refer to as Medicare "subvention." However, it was deleted from the bill before floor action because of concerns that the Senate Finance Committee had not held hearings on the concept.

**Recommendation:** (1) Test the concept of subvention at up to seven locations, as proposed by the SASC; and (2) Allow Medicare-eligible retirees access to DOD's managed care programs with HCFA reimbursement.

### Managed Care Networks at Base Closure Sites

Many retirees at base closure sites are losing access to their primary source of health care — the MTF. These retirees will now be forced to rely on CHAMPUS for their health care, at greater expense to DOD and to the beneficiary. In some cases, these retirees may have difficulty purchasing CHAMPUS supplemental care due to pre-existing medical condition clauses. It would be less expense for DOD to provide care to these individuals through managed care programs (MCP) than through CHAMPUS, and it would also be advantageous for the beneficiaries.

**Recommendation:** Support the continued expansion of the MCP to all USTFs, and require USTFs to compete with other DOD managed care programs in the area.

### Improve Management of CRI

When the CHAMPUS Reform Initiative (CRI) was initiated as an at-risk contract in California and Hawaii five years ago, its goals included better access, while maintaining quality of care, and reduced CHAMPUS cost growth. CRI has proven to be highly popular with military beneficiaries, especially retirees, due to improved access to care and quality services. The initial cost evaluation suggested that CRI was saving significant amounts compared to standard CHAMPUS. A more recent analysis by RAND, not subscribed to by other independent analysts, suggests higher costs to DOD. Several possible factors may have contributed to the perceived higher costs under CRI. For example, the resource-sharing arrangement provided by the contractors has an inherent bias to shift the more costly patients to the MTFs; administrative costs under CRI are approximately 15 percent, which appears high; greater utilization of outpatient and preventive services under Prime; and, uncontrolled access to primary care services due to ineffective controls by "gatekeeper" providers.

**Recommendation:** Keep the CRI program in its current form but implement modifications to make CHAMPUS Prime more cost-effective.

### Improve Customer Satisfaction



Care provided through the Military Health Services System is not "user friendly" and, therefore, not as efficient as it could be. It is difficult to reach the MTF by phone and equally as difficult to schedule appointments in specialty clinics. This drives prospective patients away from the MTFs. CHAMPUS forms are difficult to fill out and when not completed properly result in secondary or tertiary submissions and delayed reimbursements. Computer-generated denials of claims are cold and insensitive, and contribute to the "hassle" factor. Finally, communications between provider and patient, and between patient and fiscal intermediary, need improvement.

**Recommendations:** Support state-of-the-art appointment scheduling and telephone systems in MTFs; streamline CHAMPUS claims processing; introduce more sensitivity in communications between the patient, provider and the fiscal intermediary; and, standardize federal forms.

### **Diminished Dental Coverage**

It is difficult for military retirees and their dependents to obtain dental care at military dental clinics. Any dental care at all is provided on a space-available basis. Dependents of active duty personnel, on the other hand, do have access to a DOD-sponsored insurance dental plan. "Gray area" retirees (reservists who have retired but are not drawing their retirement pay yet) and reservists and their dependents do not have access to dental care through DOD. Reservists can receive emergency dental care when they are on active duty during their annual training. Many reservists were not mobilization-ready during Desert Storm due to lack of dental care.

**Recommendations:** (1) DOD should implement a dental plan for military retirees and their dependents, for "gray area" retirees and for reservists, similar to the plan available for dependents of active duty personnel; and, (2) Retirees should be automatically enrolled in the plan upon retirement, with a 120-day period in which the retiree could cancel the plan if desired, unless the plan has been used.

### **Preserve Independent MHSS**

National health care reform proposals may incorporate the Military Health Service System (MHSS) into a nationalized health plan that would adversely affect the ability of the Department of Defense and the Department of Veterans Affairs to meet their contingency and readiness missions.

The primary mission of the Department of Defense is to protect the national interest and the national security of the United States. To do so, it must be prepared to defend its interest, both foreign and domestic, by maintaining a well-equipped and well-trained force that is ready to deploy anywhere in the world on short notice. Therefore, the MHSS and the VA health care system should continue to assure that American servicemen and servicewomen are able to receive the best quality care they need and deserve.

Further, the resources required by DOD and the VHA must be adequate to meet their health care missions. The VHA must be able to honor its commitments to all entitled veterans by providing for their special needs, such

as head and spinal cord injuries, rehabilitation services and the treatment of post-traumatic stress disorder, which is often found in combat.

For those who serve and have served in the Armed Forces, and their families, their health care benefits must be assured and be uniform, comprehensive and equitable, including preventive health care services and prescription drugs. If cost-sharing is required for health care services, such charges should be affordable and equitable. This is now the case as evidenced by the difference in cost-share when members and their families are stationed near a military treatment facility and when members are assigned away from such support facilities and their families must use CHAMPUS.

Access to health care services must be timely and assured for all DOD beneficiaries, i.e., care must be provided, when it's medically necessary, without hassle and inordinate delays.

Finally, VA/DOD resource-sharing arrangements that reduce duplication of services and maximize the use of federal resources should be continued and expanded where its appropriate to do so. Over 3,000 agreements now exist, saving the federal government millions of dollars.

**Recommendation:** The MHSS and the VA must remain independent if they are to meet their congressionally mandated missions, and any proposal to integrate these systems into one monolithic federal health care agency or into a national health care system should be strongly opposed.

Mr. Chairman, that concludes my presentation. I thank you for the opportunity to participate in your hearing and hope you will consider the Air Force Sergeants Association's suggestions and recommendations on Health Care for members of the Armed Forces, active duty, Guard, Reserve, retired, veteran, and their families.

## STATEMENT OF ALLAN JENSEN, M.D., SECRETARY FOR FEDERAL AFFAIRS, AMERICAN ACADEMY OF OPHTHALMOLOGY

### I. Introduction

As the debate over health care reform draws closer to reality, everyone agrees that inequities in insurance coverage and escalating costs of care must be fixed. Universal access to health care in America has been hailed as a moral, medical and social imperative. The American public believes that everyone should be entitled to health care, and is increasingly disconcerted about the gaps and barriers in obtaining coverage for needed services. Since the 1970s, every other major industrialized country in the world except the United States had created a nationwide system to guarantee each of their citizens access to health care.

To build an universal access plan, benefits which cover essential health care services need to be defined. Many proposals for health care reform have labelled this a "basic benefit package." Every American would be assured of access into mainstream health care through entitlement to the same benefits. Guaranteed coverage would serve as a safety net, and could be supplemented by purchase of additional insurance.

The American Academy of Ophthalmology strongly supports universal access to necessary medical care. The proposal for a basic eye care benefit package encompasses care that promotes eye health and good vision for all Americans. It provides for

- ▶ preventive care and screenings that detect disease early in order to reduce visual loss or avoid blindness;
- ▶ periodic eye evaluations at prescribed intervals; and
- ▶ appropriate medical and surgical treatment to take care of the patient throughout his/her lifetime.

Timely vision and eye health screenings are especially important for maintaining good vision and educational achievement of America's children. Early detection of defective vision allows the opportunity to provide more effective and less expensive treatment. Periodic eye examinations are important to detect frequently occurring conditions as well as less common but more serious diseases in adults.

This package provides a more cost-effective solution than is provided for in the current, fragmented system. Increased access to preventive care and timely treatment should result in better health and reduce overall costs of disease treatment.

### II. Background

Eye care is an integral component of health care and contributes to the well-being and daily functioning of American citizens. Vision is the principal pathway for learning for the young, and primary means of communication for adults. Vision is vital for acquiring skills and maintaining optimal performance in today's high technology society.

Disorders and diseases of the visual system are widely prevalent. At least one-fourth of all Americans have optical abnormalities, and one-third have a medical or surgical disease of the eye and visual system (AAO Comprehensive Adult Eye Evaluation Preferred Practice Pattern, 1992). Nearly 11.5 million persons in the U.S. suffer from vision impairment to some degree, and half a million are unable to lead normal, productive lives (National Society to Prevent Blindness). There is still a great need for eye care. It is estimated that approximately one-third of all new cases of blindness could have been prevented if patients were to receive appropriate treatment in a timely manner.

Tremendous strides have been made through ophthalmologic advances in the detection and treatment of eye disease. Advances in the treatment of cataracts, diabetic retinopathy and glaucoma have enabled many millions of Americans to retain visual function and lead productive lives. Treatments that prevent visual loss and disability produce significant savings to society. For example, early screening and treatment of diabetic retinopathy is estimated to cost \$966 a year for saving the sight of each person, compared with an average

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annual cost of \$6,900 in social security disability payments (Javitt et al: "Cost effectiveness of current approaches to the control of retinopathy in Type I diabetics." Ophthalmology, Volume 96, 1989)

Ophthalmology, as part of the medical profession, is dedicated to the basic purpose of care in order to enhance the health of an individual person and society through early diagnosis and timely treatment of ocular and systemic disease processes. The ophthalmologist views each patient as a complex, integrated human being with other medical conditions, with the ultimate goal of promotion of health of the whole person.

Basic eye care benefits should be considered together with other medical care benefits because of the close interrelationship between the eye and other organ systems. The eye is a microcosm of the whole body and inextricably affected by systemic disease processes. Signs of a systemic disease may be first detected during an eye examination. Diabetes, hypertension, AIDS, many brain tumors or disorders of the brain, hematological or immunological disorders can often be detected first through ocular signs. Medications prescribed for systemic diseases could have untoward and undesirable side effects on the eye and visual system, and vice versa. For example, medications commonly used to treat glaucoma such as beta-blockers have effects on the cardiac and pulmonary systems. In the treatment of immune diseases or respiratory diseases, the use of steroids might induce eye diseases such as cataracts or glaucoma.

### III. Criteria for Basic Eye Care Benefit Package

Basic benefits include appropriate and effective health care services. Services need to be evaluated scientifically in order to determine appropriate clinical indications for use and efficacy. The basic benefits should be specific and clearly delineated for ease of implementation and oversight by third parties. The following criteria form the core basis for defining the package:

Criteria for Inclusion:

1. The basic package should be **sufficient to assure good vision and eye health** for the American public.
2. The basic package should promote **preventive care** (screenings and exams to **detect disease** as early as possible and to prevent blindness) as a method to promote public health, to reduce human suffering and to contain health care costs.
3. The basic package should provide for **timely and clinically indicated medical and surgical intervention** to treat eye diseases and maintain good vision and eye health.
4. The basic package should emphasize **fiscal responsibility**, by providing for prompt and efficacious care that reduces patient illness and disability, and that improves patient outcome and visual function in a cost-effective manner.
5. The basic package should protect the public by providing coverage of **clinically effective care**. Coverage decisions should be based on scientific determinations of safety and efficacy wherever possible.
6. The basic package should enhance the quality and cost-effectiveness of care by **specifying appropriate care**. Appropriate care is medically indicated and necessary, and given in a competent manner. Appropriate care is defined by RAND as follows:

*"A procedure or service is appropriate if its health benefit exceeds its health risk (with the explicit exclusion of cost) by a sufficiently wide margin that the service or procedure is worth performing."*

(Appropriateness depends on the particular circumstances for a patient. For some patients, procedures might pose too much risk or too little marginal benefit to justify their use. Physicians and other health care professionals should have the ability to



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work with the patient to determine the most appropriate course of treatment, within the limits of their scope of expertise and skills, the particular circumstances of the patient, state of scientific knowledge, and existing practice standards. A specific procedure might be appropriate for one patient, in contrast with another type of patient. Furthermore, a procedure might be appropriate for a patient in one circumstance and not appropriate under a different set of circumstances.)

**Exclusions from the Basic Benefit Package:**

The following list defines options proposed to be outside of the basic benefit package, which the patient is free to purchase through additional coverage or from out-of-pocket.

1. **Experimental drugs or treatments** not yet approved by the FDA or not included in current accepted practices or standards of care.  
However, patient care in approved clinical trials has been paid by Medicare and other insurers traditionally, and this research should continue to be supported.
2. **Procedures or treatments unproven to be effective, safe, or appropriate** based on scientific evidence or lack thereof.  
For example, marijuana has been shown to be ineffective in the treatment of glaucoma. Pinhole glasses have not been proven to be effective for improving vision. There has been no satisfactory scientific evidence to show any relation between visual training and performance (National Academy of Sciences, 1988).
3. **Routine tests/exams that are not medically necessary** in promoting eye health.  
For example, a routine annual eye examination in healthy people between the age of 18 and 40 years would not be considered cost-effective for routine coverage, or necessary for detecting disease, in the absence of other indications, eye symptoms or change in visual function.
4. **Supplemental services that are not determined to be medically indicated.**  
This includes some forms of refractive surgery when performed for nonmedical indications, cosmetic contact lenses, and cosmetic ophthalmic surgical services.
5. **Supplemental services that are used broadly by the population.**  
This includes refraction exams alone, eyeglasses for adults, nonprescription drugs and sunglasses. Nearly everyone will need refractions and glasses at periodic intervals in their lives. Universally used services are not generally covered by insurance. These services would not pose an unreasonable burden on most patients to pay out-of-pocket.

Other services, such as prescription drugs, low vision rehabilitation, prosthetics (i.e., prosthetic eyes) and low vision devices, are important for optimal visual function or patient outcome. These have not always been covered under medical indemnity coverage. To the extent that basic coverage for all medical care includes prescription drugs, rehabilitation and prosthetic devices, then ophthalmic drugs, low vision rehabilitation and ocular prostheses should be considered in the same category and be covered. If these categories of services are not universally covered, then there should be a funding mechanism to guarantee access to these services for those patients who cannot afford them, protecting them from undue financial hardship.

**IV. Financial Responsibility for Services**

The public, the government, third parties and providers all agree that there is an increasing burden placed by growing health care expenditures. Necessary, appropriate and effective services should be covered in an universal access system, not adding unnecessarily to the ordinary costs of care. Normally, insurance coverage is intended to cover an individual for unforeseen risks and costs, e.g., the expense of a catastrophic illness. Lower cost services

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that are predictable and used broadly are not usually considered insurable risks. An exception is made for preventive services, in order to encourage and optimize their use by the general population.

In the proposed system, patients should be guaranteed access, regardless of their ability to pay. However, cost-sharing among patients promotes a measure of individual responsibility for health care expenditures. Co-payment is recommended as a feature for all financing, with a funding mechanism and a reasonable out-of-pocket expense cap to provide for patients who cannot afford necessary services. Some patients may also need financial assistance to afford supplemental services which are important for daily function, although most patients are expected to have the means to pay themselves.

#### **V. Definition of Basic Eye Care Benefit Package**

In order to ensure every American equal opportunity to good vision and eye health, basic eye care services should be made accessible for all, regardless of his/her ability to pay. The basic eye care benefit package includes the following:

For healthy patients with no known eye disease:

- (1) preventive vision screenings and eye health screenings for children
- (2) preventive basic eye evaluations for adults
- (3) periodic comprehensive eye examinations for adults in general population
- (4) periodic comprehensive eye examinations for groups at high (statistically greater) risk for developing eye disease

For patients with eye disease:

- (1) periodic comprehensive medical eye examinations and other medical eye exams, including consultant and referral services
- (2) medical testing and diagnostic services, including laboratory and radiologic services
- (3) medical treatment of eye diseases on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
- (4) surgical evaluation and treatment on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
- (5) follow-up and monitoring

#### **VI. Fundamental Services**

The fundamental services provided in the basic benefit package are described as:

- 1) vision screening and eye health screening;
- 2) a basic eye evaluation;
- 3) a comprehensive eye examination;
- 4) medical and surgical services.

Patient education is an essential component of preventive services to provide patients with information on how to avoid eye injuries, reduce risk factors for disease, develop healthier behaviors and promote the benefits of early disease detection. For care to be optimal, patients need to be made aware of the importance and benefits of early detection and treatment of eye diseases and conditions, and take more responsibility for their own health.

There are two kinds of eye screenings. The **vision screening** consists of a testing of distance Snellen acuity with the patient utilizing the current spectacle correction (if any) for the purpose of detecting visual problems. It is not a truly diagnostic procedure and cannot detect all visual problems nor identify their causes. The screening is usually performed quickly, as accurately as possible and at the lowest cost in order to serve the general population. It is most useful on a periodic basis for detecting visual problems in the pre-school and school-age population. An **eye health screening** consists of a vision screening with a general, brief history of any symptoms or previous eye diseases, and an abbreviated

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evaluation of the pupil, ocular alignment and motility, and the fundus. This does not require dilation of the pupil and could involve an ophthalmoscopic examination and intraocular pressure measurement. This is useful in a pediatric population where risks of developing eye disease are fairly low, but more common eye conditions can be screened through simple testing (strabismus and amblyopia). These screenings can be performed by a variety of providers.

A **basic eye evaluation** consists of a general history of the patient, complete history of eye symptoms or previous eye diseases and a brief evaluation of the gross anatomic and physiologic status of the eye. This would include a slit-lamp examination and ophthalmoscopic examination, but would not require dilation of the pupil. Testing of extraocular muscle motility, including binocularity testing, determination of visual acuity, measurement of intraocular pressure and a pupillary evaluation would be included. The basic eye evaluation should be performed by a qualified eye professional.

A **comprehensive eye examination** is a more thorough medical exam, and consists of three major components: medical history, history of any eye conditions, and evaluation of physiologic function and anatomic status. A thorough history collects demographic data, past history, other systemic conditions, use of systemic and topical medications and other relevant information. During this process, information about the patient's general health status and any systemic symptoms are evaluated and interpreted. The evaluation of physiologic function includes, but is not limited to the following: measurement of visual acuity with present correction, measurement of best corrected visual acuity obtained by refraction, testing of ocular alignment and extraocular muscle motility, evaluation of pupillary status and measurement of intraocular pressure. The evaluation of the anatomic status of the eye focuses on three areas: lids, lashes, lacrimal apparatus, orbit and other pertinent features; anterior segment, including the conjunctiva, sclera, cornea, anterior chamber, iris, lens and posterior chamber; and posterior segment, including the retina, vitreous, uvea, vessels and optic nerve. Examination of the posterior segment is best performed and usually done through a dilated pupil and examination with a direct and indirect ophthalmoscope. A comprehensive eye examination should be performed by an ophthalmologist because of the need to have expert interpretation of the general medical history and systemic signs and symptoms related to the patient's visual function and overall health status.

An examination specifically directed towards prescription of corrective lenses is not defined as a fundamental service, but a diagnostic refraction is an integral part of a comprehensive eye examination that is indicated at appropriate intervals. A refractive exam consists of a quantitative measurement that yields the data necessary to determine the best visual acuity with corrective lenses and to prescribe these lenses.

**Medical and surgical services** include ordering and performing of appropriate supportive testing, prescription of pharmacologic treatment, performance of other medical procedures, evaluation for surgical treatment, performance of surgical procedures, including laser surgery, delivery of post-operative care, follow-up and monitoring of patients with eye diseases. Ophthalmologists, by virtue of their broad medical expertise, schooling them in diagnostic abilities and clinical decisionmaking in general patient management, and their specialized medical study of the visual system and training in treatment methods, should perform medical and surgical services for the diagnosis and treatment of eye diseases.

## VII. Proposed Elements of the Package

The following briefly describes the schedule for periodic eye examinations for children, adults and high-risk groups with more detailed tables included as Attachment A.

### **Children:**

For all children, early comprehensive eye examinations are important to detect or evaluate inborn or congenital eye abnormalities and those associated with prematurity. These include fixation preference, ocular misalignment or ocular



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diseases leading to amblyopia, cataracts, glaucoma or tumor. There should be an eye health screening when the baby is in the nursery and at six months of age. There should be an eye health screening at approximately 3 years and 5 years of age. An initial comprehensive eye examination should be performed when a child is between three to six years of age. Between 7 to 18 years, children should have an eye health screening, and receive vision screenings at ages 8, 12, 14 and 18 years.

#### **Adults:**

For the general adult population without symptoms or other indications between the ages of 19 and 39 years, an initial comprehensive eye examination is indicated. In the absence of risk factors, symptoms or other indications, these healthy adults do not require routine annual evaluations. African Americans between the ages of 20 – 39 years old require a comprehensive eye examination every 3–5 years, because of a higher incidence and more aggressive course of glaucoma. All adults aged 40 to 64 years old should have a basic eye evaluation every 2–4 years, and a comprehensive eye examination once between the ages of 40 and 60 and once around the age of 65. A comprehensive eye examination should also be performed when indicated by risk factors, signs or symptoms.

#### **High-Risk Groups:**

For patients, both adult and children, at high (statistically greater) risk to develop eye diseases, such as having a systemic disease associated with eye problems, use of systemic medications with ocular complications, history of risks of eye injury due to vocation, or family history of eye disease, the frequency and intensity of examination should be increased to detect the onset of vision-threatening diseases as promptly as possible. Comprehensive eye examinations should be provided at appropriate intervals, with frequency depending on the risks encountered, the patient's condition and likelihood for detecting onset of disease as determined by clinical judgment.

#### **Patients with Eye Symptoms and Diseases:**

Patients who have signs or symptoms may first be identified through a screening or eye health screening. After a screening evaluation, children warrant a comprehensive eye examination if they have abnormalities upon exam; signs or symptoms of eye problems by history; multiple health problems, systemic diseases or use of medications associated with eye disease; relevant family history; or health and developmental problems that make screening difficult. (AAO Comprehensive Pediatric Eye Evaluation Preferred Practice Pattern, 1992)

The following eye symptoms or systemic diseases warrant referral for a prompt comprehensive eye examination: failure to achieve normal visual acuity in either eye unless cause of impairment has been medically confirmed by prior examination and visual acuity is stabilized, significant eye injury or eye pain, flashes of light, recent onset of floaters, halos, transient dimming or distortion of vision, obscured vision, loss of vision or pain in the eye, lids or orbits, double vision or excessive tearing, loss of any part of the visual field, abnormalities in the transparent media of the eye or in the fundus or optic nerve head; tumor or swelling of eyelids or orbit, protrusion of one or both eyes, inflammation of lids, conjunctiva or globe, with or without discharge, strabismus, abnormal intra-ocular pressure, diabetes mellitus, eye abnormalities associated with thyroid disease, HIV-positive patients with ocular symptoms and all patients with AIDS. (AAO Guidelines for Appropriate Referral of Persons with Possible Eye Diseases or Injuries, 1992)

Individuals with acute eye symptoms should have a prompt comprehensive eye examination and appropriate follow-up visits. For patients with defined eye diseases or decreased visual function, appropriate medical and surgical services should be provided for



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diagnosis and treatment of their conditions. These services should meet the test of medical necessity and reasonable provision of care, based on current practice guidelines, and should be provided by qualified professionals. Patients with chronic eye diseases should be evaluated periodically, with the frequency of visits depending on the severity of the condition, the response to therapy and the potential for disease progression.

**VIII. Supplemental Eye Care Benefits**

Supplemental services are services that patients may elect to purchase, or providers may elect to provide, but are not covered in the basic benefit package. Some supplemental services are very important for daily functioning and optimal visual function, but because of their relatively low costs to each individual and broad use in the population, do not appear to warrant universal coverage. Other services are considered more discretionary, e.g., cosmetic procedures, and are not included in an universal coverage plan. Ophthalmologists and other eye care professionals, such as optometrists, opticians, orthoptists, ocularists and others, can provide some of these services as part of a plan provided to their patients, or as separate optional services.

**List of Supplemental Services**Vision Services:

- Refraction Alone (other than refractions included in basic periodic evaluations)

Dispensing and Supplying of Eye Glasses:

- Prescription of spectacles (except for aphakia)
- Fitting of spectacles (except for aphakia)
- Repair and refitting spectacles (except for aphakia)
- Supplying of spectacles (except for aphakia)
- Prescription, fitting and supply of protective eyewear for work and sports-related activities

Measurement and Fitting of Contact Lenses:

- Prescription of optical and physical characteristics of and fitting of contact lens (excluding fitting of lens for treatment of disease)
- Modification of contact lens, with medical supervision of adaptation
- Supplying and replacement of contact lenses (excluding supply of lens for treatment of disease)
- Patient education about lens use, lens wear and precautions

Cosmetic Ophthalmic Surgical ServicesSurgical Procedures to Correct Refractive Error When Performed for Nonmedical Indications:

- Refractive Keratotomy
- Myopic Keratomileusis
- Epikeratoplasty
- Corneal Inlays
- Photo-refractive Keratectomy
- Intracorneal Ring
- Hyperopic Keratomileusis

variant Causes of Eye Pathology:  
Retinopathy of Prematurity  
Strabismus and amblyopia  
Congenital and hereditary eye  
diseases and drug related problems

[illegible]

American Academy of Ophthalmology Policy Statement "Infant and Child Vision Examination"

1661 2007

American Academy of Ophthalmology Preferred Practice Pattern, "Comprehensive Pediatric Eye Evaluation," June 1992

American Academy of Pediatrics, Periodicity Table, Committee on Practice and Ambulatory Medicine

See American Academy of Ophthalmology. *Binocular, "Amblyopia," "Strabismus," and "Eyeglasses for Infants and Children" and Eye Test Sheet, "Retinopathy of Prematurity."*

Important Causes of Eye Pathology:  
Strabismus  
Amblyopia  
Injury

<p><b>EXAMINATION:</b> General Inspection.</p> <p><b>History and Physical Exam:</b></p> <p>Eye Inspection (Screening for Eye Health and Visual Acuity, at approximately 3 Years of age and at 4-5 Years of age)</p> <p>Comprehensive Examination between the ages of 3 and 5 years old</p> <p><b>Reflexes/Changes:</b> Infants with a family history of retinoblastoma, congenital glaucoma, strabismus, high refractive error, other genetic diseases, or genetic abnormalities, should be screened for retinoblastoma. The presence of a family history of retinoblastoma is a red flag for an ophthalmologist as the risk of retinoblastoma is 10% for children with a family history of the disease. History of physical abuse. History of ocular trauma.</p> <p><b>History and Physical Exam:</b></p> <p>Eye Examination for Eye Health and Visual Acuity at appropriate intervals, 2+ times per year</p> <p>When the screening eye exam is reported as a risk of eye disease, or screening procedures by a neuro-ophthalmologist, referral to an ophthalmologist for an eye examination is necessary.</p> <p><b>PASBENT EDUCATION:</b></p> <p>General Population</p> <p>Awareness of signs of childhood eye disease.<sup>3</sup></p>	<p><b>EXAMINATION:</b> General Inspection.</p> <p><b>History and Physical Exam:</b></p> <p>Eye Inspection (Screening for Eye Health and Visual Acuity, at approximately 3 Years of age and at 4-5 Years of age)</p> <p>Comprehensive Examination between the ages of 3 and 5 years old</p> <p><b>Reflexes/Changes:</b> Infants with a family history of retinoblastoma, congenital glaucoma, strabismus, high refractive error, other genetic diseases, or genetic abnormalities, should be screened for retinoblastoma. The presence of a family history of retinoblastoma is a red flag for an ophthalmologist as the risk of retinoblastoma is 10% for children with a family history of the disease. History of physical abuse. History of ocular trauma.</p> <p><b>History and Physical Exam:</b></p> <p>Eye Examination for Eye Health and Visual Acuity at appropriate intervals, 2+ times per year</p> <p>When the screening eye exam is reported as a risk of eye disease, or screening procedures by a neuro-ophthalmologist, referral to an ophthalmologist for an eye examination is necessary.</p> <p><b>PASBENT EDUCATION:</b></p> <p>General Population</p> <p>Awareness of signs of childhood eye disease.<sup>3</sup></p>
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<sup>4</sup> Corroborated by recommendations of the U.S.

3 American Academy of Ophthalmology Policy Statement, "Infant and Children's Vision Screening."

June 1991

4. American Academy of Pediatrics. Periodicity Table. Committee on Prevention and Control of Infectious Diseases. June 1992.

Medicine, and Vision Screening Guidelines, American Academy of Ophthalmology; American Academy of Pediatrics and American Association of Pediatric Ophthalmology; and Strabismus

<sup>3</sup> See American Academy of Ophthalmology Patient Information Brochures, "Amblyopia," "Strabismus," "Eye Injuries," and "Eye Safety for Children."

Strabismus  
Injury  
Refractive Errors

**EXAMINATION:**  
Oral and Written

**History and Physical Exam:**

*Eye Deviation (Decreasing) for Eye Health and Visual Acuity 1,2*  
*Visual Scanning at ages 4, 12, 14, and 18 years of age 1,4*

**Multidisciplinary:**

**History and Physical Exam:**

Patients with chronic radicular Compromised Eye Examination 3 years after onset of  
stroke with mild, partly known or unknown

Patients with other systemic diseases or other genetic diseases associated with eye problems  
or previous stroke trauma Compromised Eye Examination at appropriate intervals

<sup>1</sup> When visual-evoked eye disease is suspected as a result of eye conditions or abnormal perception by a  
neurologist, referral to an ophthalmologist for eye examination is necessary.

**FATFED AND JABET EXAMINATION**

History previous condition <sup>4</sup>

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American Academy of Ophthalmology Policy Statement, "Infant and Child's Vision Screening,"  
June 1991

<sup>1</sup> American Academy of Ophthalmology Preferred Practice Pattern, "Comprehensive Podiatric Eye Evaluation," June 1992

<sup>3</sup> American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care, 1990; and American Academy of Pediatrics Periodicity Table, Committee on Prevention and Ambulatory Medicine

4 American Academy of Ophthalmology, American Academy of Pediatrics, and American Association of Pediatric Ophthalmology and Strabismus. Vision Screening Guidelines. 1993.

<sup>1</sup> American Academy of Ophthalmology Preferred Practice Patterns. \* Duke J. Ruzicapsky.  
September 1980.

<sup>6</sup> See American Academy of Ophthalmology Patient Information Brochures, "Eye Injuries" and "Eye Safety for Children."

Table 4. Ages 19 - 39 years	Important Causes of Eye Pathology Diabetic Retinopathy Traumatic Eye Injury
<b>EXAMINATION*</b>	
<b>General Examination:</b>	
History and Physical Exam:	
Comprehensive Eye Examination, with scheduling with to distant vision <sup>1</sup>	
<b>Vision/Visual Changes:</b>	
Individuals at risk for eye injury due to occupation: Comprehensive Eye Examination is necessary	
<b>History and Physical Exam:</b>	
Patients with onset of diabetes mellitus after age 30 years: Comprehensive Eye Examination at time of diagnosis and follow-up every year <sup>2</sup>	
Patients who onset of diabetes mellitus before 30 years of age: Comprehensive Eye Examination every 3 years <sup>3</sup>	
<b>Visual/Visual Changes:</b>	
Adverse American: Comprehensive Eye Examination with attention to measurement of optic nerve intra and limbal pressure at appropriate intervals <sup>1</sup>	
Patients with a family history of glaucoma, other genetic diseases, other genetic diseases associated with eye problems, use of systemic medications, history of ocular trauma: Comprehensive Eye Examination at appropriate intervals <sup>1</sup>	
* When vision-threatening eye disease is suspected as a result of an eye examination or screening procedure by a comprehensive eye examination, referral to an ophthalmologist for an eye examination is necessary.	
<b>PATIENT EDUCATION:</b>	
Awareness of benefits of early detection and treatment of major eye disease <sup>4</sup>	
Prevention of recurrence and work-related eye injury	
<b>1</b> American Academy of Ophthalmology Preferred Practice Pattern, "Comprehensive Adult Eye Examination," June 1991.	
<b>2</b> American Academy of Ophthalmology Preferred Practice Pattern, "Work-Related Eye Injuries," 1989.	
<b>3</b> American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>4</b> American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>5</b> American Academy of Ophthalmology Preferred Practice Pattern, "Comprehensive Adult Eye Examination," June 1991.	
<b>6</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Glaucoma Support," September 1989.	
<b>7</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>8</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	

Table 5. Ages 40 - 64 years	Important Causes of Eye Pathology Glaucoma Diabetic Retinopathy Traumatic Eye Injury
<b>EXAMINATION*</b>	
<b>General Examination:</b>	
History and Physical Exam:	
Basic Eye Examination every 2-4 years	
Comprehensive Eye Examination between age 40 and 64 years	
<b>Vision/Visual Changes:</b>	
Individuals at risk for eye injury due to occupation: Comprehensive Eye Examination is necessary	
<b>History and Physical Exam:</b>	
Patients with diabetes mellitus: Comprehensive Eye Examination every year <sup>2</sup>	
Adverse American: Comprehensive Eye Examination with attention to measurement of optic nerve intra and limbal pressure at appropriate intervals <sup>1</sup>	
Patients with a family history of glaucoma, other genetic diseases, other genetic diseases associated with eye problems, use of systemic medications, history of ocular trauma: Comprehensive Eye Examination at appropriate intervals <sup>1</sup>	
* When vision-threatening eye disease is suspected as a result of an eye examination or screening procedure by a comprehensive eye examination, referral to an ophthalmologist for an eye examination is necessary.	
<b>PATIENT EDUCATION:</b>	
Awareness of benefits of early detection and treatment of major eye disease <sup>4</sup>	
Prevention of recurrence and work-related eye injury	
<b>1</b> American Academy of Ophthalmology Preferred Practice Pattern, "Work-Related Eye Injuries," 1989.	
<b>2</b> American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>3</b> American Academy of Ophthalmology Preferred Practice Pattern, "Glaucoma Support," September 1989.	
<b>4</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>5</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>6</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>7</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>8</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	

Table 6. Ages 65 and older	Important Causes of Eye Pathology Macular Degeneration Glaucoma Diabetic Retinopathy Traumatic Eye Injury
<b>EXAMINATION*</b>	
<b>General Examination:</b>	
History and Physical Exam:	
Comprehensive Eye Examination at 65 years old	
Basic Eye Examination every 1-2 years	
<b>Visual/Visual Changes:</b>	
History and Physical Exam:	
Patients with diabetes mellitus: Comprehensive Eye Examination every year <sup>2</sup>	
Adverse American: Comprehensive Eye Examination with attention to measurement of optic nerve intra and limbal pressure at appropriate intervals <sup>1</sup>	
Patients with a family history of glaucoma or retinal degeneration other systemic diseases, other genetic diseases associated with eye problems, use of systemic medications, history of ocular trauma: Comprehensive Eye Examination at appropriate intervals <sup>1</sup>	
* When vision-threatening eye disease is suspected as a result of an eye examination or screening procedure by a comprehensive eye examination, referral to an ophthalmologist for an eye examination is necessary.	
<b>PATIENT EDUCATION:</b>	
Awareness of benefits of early detection and treatment of major eye disease <sup>4</sup>	
Prevention of eye injury	
<b>1</b> American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>2</b> American Academy of Ophthalmology Preferred Practice Pattern, "Glaucoma Support," September 1989.	
<b>3</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>4</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	

Table 7. Pregnant Women	Important Causes of Eye Pathology Diabetic Retinopathy Traumatic Eye Injury
<b>EXAMINATION*</b>	
<b>General Examination:</b>	
Patients with onset of diabetes during pregnancy and diabetic patients who become pregnant	
<b>History and Physical Exam:</b>	
Comprehensive Eye Examination <sup>1</sup> in the first trimester and a 3 month follow-up interval during pregnancy	
* When vision-threatening eye disease is suspected as a result of an eye examination or screening procedure by a comprehensive eye examination, referral to an ophthalmologist for an eye examination is necessary.	
<b>PATIENT EDUCATION:</b>	
Awareness of the signs for first onset symptoms such as vision changes or blurring	
<b>1</b> American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>2</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	
<b>3</b> See American Academy of Ophthalmology Preferred Practice Pattern, "Diabetic Retinopathy," September 1989.	

## STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a professional association representing 36,000 respiratory care practitioners, welcomes the opportunity to submit written testimony before the Ways and Means Sub-Committee on Health hearing on the benefits package of health care reform.

Respiratory care is an allied health care specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and people of all ages, who require the use of a ventilator to breathe, are often cared for by the respiratory care professional.

Perhaps the single most difficult component in configuring a cohesive national health plan centers around the development of a benefits package. A core question raised is whether the benefits will be "basic" in nature, or whether the benefits will be "comprehensive". The debate, then, will focus on the definition of basic versus comprehensive. One person's comprehensive package may be another's basic benefit package. While it may be desirous to provide for all medically appropriate and justifiable services, it appears that fiscal reality simply will not permit such an action. This represents a fundamental change in our health care system. Today, if you are fortunate to have a generous insurance policy, or the personal financial resources, nearly any health care service may be obtained. It appears now that the wide disparity in benefits available to individuals will be significantly curtailed with the implementation of health care reform. Further, adding to the difficulty of the health care debate, is the decision facing Congress as to what entity will determine what services constitute a basic or comprehensive component of the final benefits package. Will Congress legislate the services/suppliers/providers under reform legislation, or will the benefits decision be determined by an independent "National Board"?

The members of the AARC recognize that the viewpoints of one association will not alter the course Congress or the Administration will take as it tackles health reform. We believe, however, it is our responsibility to make Congress and the Administration aware of the role the respiratory care practitioner plays in the delivery of health care. The AARC continues to struggle to reconcile outdated Medicare coverage policies with the realities of late 20th century medicine and therapy. Our greatest concern is that Congress or a national health board will merely adopt the current set of Medicare benefits, thus perpetuating an outdated mode of respiratory care services. Secondly, we fear that if a benefits package simply states coverage for "home health care," "rehabilitation services," and "nursing home services," then the interpretation of what compromises those services will come back to rest with current Medicare policy. Once again, the roles that respiratory care practitioners play in the delivery of alternate site health care services may not be recognized.

While medical technology may be advancing, the Medicare and Medicaid coverage provision remains stagnant, reflecting the type of respiratory care practiced in the late 1960's. An extension of current coverage would not address the issue of respiratory care services to patients outside the hospital. Patients who would benefit from the less expensive, nonhospital-based respiratory care services would still remain tethered to the institution, as is the current Medicare population.

We would strongly urge the members of the Sub-Committee to assess the evidence of the cost-effectiveness and appropriateness of respiratory care services in alternate sites.

Respiratory care is playing an increasingly important role as part of the comprehensive array of services available in rehabilitation sites. For example, since 1982, respiratory care has been a covered service under Medicare's Comprehensive Outpatient Rehabilitation Facility (CORF) benefit. Furthermore, since 1978, the federal government has covered "Outpatient Pulmonary Rehabilitation" under the Federal Black Lung Program. Congress has specifically noted the cost-effectiveness of this respiratory care service by stating in the Appropriations Conference Report the following: "Further, DCMWC (Division of Coal Mine Workers Compensation) believes that properly administered pulmonary rehabilitation will reduce the need for future medical treatment, which would eventually prove more costly to the program."



Studies documenting the importance of respiratory home care abound. There is a preponderance of evidence on the cost-effectiveness and efficacy of providing respiratory care in alternate sites. The studies have varied in methodology, scope, and time frame. The conclusion, however, is still the same: **respiratory care saves money.**

- o A 1991 Lewin/ICF economic analysis focused on the effect of availability of home medical equipment services on the cost of care for patients in three separate diagnostic categories. One of the categories studied was patients suffering from chronic obstructive pulmonary disease (COPD) (i.e., those suffering from a degenerative disease of the lungs). Lewin/ICF determined that \$520 per patient per episode would be saved if a COPD patient was to receive care in the home rather than in the hospital. With an estimated patient population of 93,000 COPD patients per year, savings to the health care system amounts to over \$48 million per year.
- o A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. The survey estimates that there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated \$789 per patient per day. This totals over \$9 million a day. Once a patient is medically able to be discharged, it takes an average of 35 days to place a chronic ventilator-dependent patient in an alternate care setting such as the home or skilled nursing facility. That translates to an excess of \$27,000 per patient in unnecessary hospital costs. Outdated reimbursement policies, which limit patients' access to respiratory care services outside the hospital, contribute to discharge delays and their subsequent excess cost.
- o In the early 1980's, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients who received home respiratory services from a qualified respiratory therapist. The results of the study show that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for those patients who were admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled \$1,097,250 (1980 dollars).
- o A 1982 conference headed by former Surgeon General C. Everett Koop on home care alternatives resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than \$15,000 per patient per month. Over the 34 month period of the pilot program, \$3.1 million in savings were realized due to the availability of home care for these children.
- o In 1991, an Illinois-based study on ventilator-dependent infants receiving home respiratory care versus hospital-based care saved the state over \$4 million during the four-year course of the program.
- o A 1989 consensus conference co-sponsored by the AARC, the Food and Drug Administration (FDA), and the Health Resource Services Administration (HRSA) (attended by representatives from more than 60 national organizations and associations) studied the problems associated with the introduction of respiratory care equipment into the home. One consensus conference recommendation for modification of third-party reimbursement policies to allow home-bound respiratory patients to receive, when necessary, care from respiratory professionals.

The primary objective of health care reform is to provide quality care at affordable prices. The AARC urges Congress to recognize the importance of patient access to respiratory care services provided by formally trained and educated professionals in cost-effective settings.

We urge you to specifically delineate respiratory care services in any benefit package which includes outpatient services, home care services, rehabilitation services, and nursing home services.

## **Statement of the American College of Emergency Physicians**

On behalf of the over 16,400 members of the American College of Emergency Physicians (ACEP), we appreciate the opportunity to discuss the issues of health benefits and health care reform.

Society has placed a great responsibility on emergency physicians to provide a health care safety net for the most vulnerable members of our population. Emergency physicians are on the front line caring for victims of drug abuse and domestic violence, the homeless, the underinsured, and others without access to health care. For these populations, the emergency department is often the only source of care available, whether primary or urgent.

Emergency department (ED) overcrowding is a problem faced by most of our members. While the causes of overcrowding vary, many of our patients lack access to basic primary care in sites open beyond "normal" business hours and available by public transportation. We believe it is imperative to design a system that works for the patient, and provides them with care before they become so ill that they need to seek emergency services; or so frustrated with their inability to see another provider that they present to the ED.

### **Preventive Services**

For emergency physicians, it is vital that any health care benefit package provide access to preventive services. The most cost-effective medicine is that which does not allow disease and injuries to occur in the first place, such as an emphasis on proven tests which provide early detection of diseases such as cancer.

However, for emergency physicians, preventive services must be defined much broader. Too often, emergency physicians see patients who cannot read a thermometer, and do not know whether a sprained ankle should receive hot or cold applications to prevent further seriousness of the injury. Health education must be a priority, not only so patients can read a thermometer to determine if they have a fever, but also so patients will use the health care system judiciously.

Patients frequently present to the emergency department with injuries that could have been prevented, and the resulting cost to the health care system could also have been prevented. Yet our nation has not actively pursued research in injury prevention, or the promotion of information to prevent injury. ACEP believes that individuals have a responsibility to choose activities leading to healthy lifestyles. However, they need information and incentives in order to make those decisions.

We know that wearing a seatbelt limits the harm done to individuals in car accidents, and that helmets protect motorcycle riders. Yet there currently are efforts in Congress to repeal the federal law that encourages states to have these requirements in place. Such commonsense approaches to potentially dangerous activities can save lives and money, and should not be eliminated.

In addition, the Center for Disease Control has yet to receive adequate funding for its Center for Injury Prevention, which takes a multi-disciplinary approach to research and promotion of injury prevention. While injury prevention is not a "benefit" that an individual could receive in a benefit package, it is important that we create a broader definition of health prevention, and place a priority on all possible activities to prevent disease and injury.

### **Emergency Services**

By federal law, every patient presenting to the ED must receive a medical screening exam to determine whether he suffers from an emergency medical condition. Emergency services are patient driven. Unlike any other physician specialty, emergency physicians are required by the Federal patient transfer law to provide care to all who seek it, regardless of ability to pay. Thus, emergency physicians have little control over the volume or type of patients presenting to the emergency department. Patients currently decide if they are experiencing sufficient discomfort or are in enough distress to seek emergency care. Regardless of what health care reforms are ultimately adopted, this approach should continue.

It is not unreasonable to believe that even the most prudent lay person will not understand the differences between a medical condition causing extreme discomfort that might have, in retrospect, waited several hours for a doctor's office to open, and a condition that requires immediate care. No one would want a death or significant harm to occur because a patient was so concerned about proper or improper use of the ED that he did not seek care. Therefore, it is important that health care plans recognize and offer health benefits that allow individuals to seek emergency care, if they believe it is necessary, and provide compensation for the services provided.

ACEP is aware of managed care plans that have, for example, told enrollees in all instances to call the primary care physician or the plan before calling 9-1-1. This practice is extremely dangerous. Frequently, the application of emergency services is only effective if delivered in a timely fashion. In some cases, even waiting a few minutes could result in more damage, or a more intense illness. Such practices in the name of cost containment is inappropriate, and potentially life threatening.



Another important factor that must be taken into consideration is the issue of standby or readiness costs. There is a very real economic cost of maintaining emergency physician resources on a 24 hour a day basis. Emergency departments operate around the clock, seven days a week, and, of necessity, are staffed to accommodate the maximum readiness. There is a value at the community and to the nation in maintaining readiness capabilities. Any reform initiative should recognize the significant costs for readiness or stand-by services provided by emergency physicians.

The College is also concerned about the impact that expanded managed care systems will have on access to emergency services. While ACEP understands the concept behind the increased use of managed care systems to help contain costs, emergency physicians are experiencing problems interacting with managed care plans. The College can only accept the principles of managed care so long as the needs of emergency medicine in providing quality emergency care are not compromised. Such needs include the timely authorization of services, and payment for the provision of the federally mandated screening exam. These are critical issues that must be addressed if the influence of managed care is to be expanded.

### **Trauma Services**

Emergency services and trauma services are rarely considered by individuals until they are needed by the individual or someone they know. Congress has already shown a commitment to supporting specialized trauma systems within states through the passage of the "Trauma Systems Development and Planning Act of 1990".

However, any health care reform proposal must continue a commitment to specialized trauma care. The crisis in trauma care today is due largely to the number of patients requiring trauma care who are uninsured. The College is concerned about how trauma care would be treated within a managed competition proposal, particularly in rural areas that currently have difficulty accessing trauma care.

The College believes that in the competitive environment envisioned by supporters of managed competition, it is critical that high quality emergency care remains available for all who seek it. ACEP is concerned that, in a system based purely on competition, access to high quality emergency care services for all persons could be endangered. The services provided by emergency departments, burn units, and trauma centers are critically important to the communities in which they exist. These same services would not survive in a system that operated only on the principles of price competition. Health reform must include provisions to protect the viability and quality of the nation's emergency services under managed competition.

While every hospital does not need to be a designated trauma center, trauma centers, necessary pre-hospital care, and transportation support such as helicopters are vital components of our nation's health care system which many areas currently lack, or are having difficulty maintaining. The concept of caring for an injured patient who requires the specialized care that a trauma center and its personnel can provide does not "fit" neatly into a managed competition proposal, and cannot be ignored.

### **Primary Care**

The College believes that access to "primary care" must result in more than simply having payment accepted by a provider of health services. Patients do not get sick during business hours alone. Primary care needs to be available beyond normal business hours and in a variety of sites, so that illness is treated at an early stage and not when the patient needs more costly emergency care.

In addition, emergency physicians have experienced first hand the confusion of patients who do not understand how to access the health insurance they have received. For example, a common reason for some Medicaid managed care patients to seek care in the ED is that the primary care physician assigned to them is geographically too far to reach by public transportation. Another problem is that the patient may have been assigned to a physician who is no longer participating, and therefore never reassigned to a participating primary care provider. When a patient is sick, even moderately so, the system and benefit design must be user friendly.

There is a predominant perception that non-urgent and primary care services are widely available elsewhere in the health care system. But the fact is, for the poor and uninsured, there simply are few, if any, alternatives available for the provision of these services. There are economic and logistical barriers in place that prevent these populations from seeking care at most so-called "appropriate" sites of service. It is simplistic to assume that alternate care exists for this population.

The College is also concerned that, in its efforts to achieve short-term budget savings, policy makers will prematurely establish barriers to care in the emergency department, under the rubric of so-called "inappropriate care". This could come in the form of retrospective denials of payment for emergency department services, or the imposition of high copayment levels for patients seeking care in the emergency department. Such policy decisions, allegedly designed to ensure that only "medically necessary" care is provided in the emergency department, would endanger access to emergency services for the poor and uninsured. This is the very same populations that health care reform was intended to assist.

### **Assistance to Care-givers**

The phenomenon of abandoning elderly patients in the ED has not been the subject of a national study, yet as emergency physicians, we know that it occurs. Emergency physicians believe that such cases are not the product of heartless family members who have departed for vacation, and have left the elderly patient in the ED. In fact, it is quite the opposite. Antidotal evidence shows that elderly patients are often brought to the ED because family members, who have tried valiantly to cope at home, are no longer able to emotionally or financially cope with an increasingly ill older patient. These families are often unaware of available services, or their locality simply does not provide adequate support for those taking care of an older ill patient at home.

As our nation ages, there will undoubtedly be more and more care-givers facing such a dilemma, thereby bringing patients to the ED. Emergency physicians believe that as a nation, we cannot use the ED's resources in such a manner. Benefits must be included which will assist caregivers to continue to take care of the older patient at home without causing both emotional and financial strain. A mix of respite, home health, homemaker, and other long term care benefits are a needed part of any benefit package.

### **Conclusion**

Emergency physicians will be the first to see both the successes and failures of health care reform. We look forward to working with Congress to eliminate the problems of ED overcrowding, elderly abandonment, and uninsured patients. ACEP believes that it imperative for Congress to pass true health care reform, and that the goal to provide better access and availability to primary care and other necessary services should not be lost in the accompanying debate on cost containment.

## STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), an organization of more than 33,000 physicians specializing in the delivery of health care to women, is pleased to have this opportunity to comment on primary care. We share your goal of ensuring universal access to health care, especially maternal and child health services.

Millions of pregnant women are caught in the gaps in the current health care system, leaving their health status in a vulnerable position. It is estimated that of the 37 million Americans under the age of 65 who are uninsured, 9 million are women of childbearing age. Pregnant women who lack health insurance are less likely to obtain adequate prenatal care and are more likely to face a poor pregnancy outcome than are women with health insurance. Effective prenatal care also reduces maternal and infant mortality and can reduce the rate of low-birthweight babies born in this country. Low-birthweight newborns tend to have longer hospital stays upon birth, have increased mortality risks and are susceptible to a wide range of illnesses, including neurodevelopmental handicaps and congenital anomalies. Access to our health care system is important to all people, but if Congress determines to phase-in health care reform, the discussion above demonstrates that maternity care should be the first step.

All coverage, whether through private insurance or a government-sponsored program, should, at the very least, include the following services to pregnant women. All services should be adapted to the health status of the woman and fetus.

- Pregnancy diagnosis
- Prenatal care, including fetal evaluation, health and childbirth education, linkage of prenatal care and delivery and care for new or preexisting conditions that affect the pregnancy
- Nutritional counseling
- Substance abuse counseling and treatment
- Abortion services
- Prescription drugs
- Labor and delivery in a facility appropriate for the anticipated obstetric and neonatal risk posed by the individual patient
- Postpartum evaluation and services, including family planning postpartum sterilization, and
- Social and other support services as needed, such as case management, home visiting and transportation.

Health services for the infant should be covered for at least one year. These services should include:

- Neonatal care appropriate to the needs of the infant; and
- Social and other support services as needed, such as case management, home visiting and transportation.

In addition to the services for pregnant women described above, the first step should also include family planning services, including sterilization, for all women. Family planning services are fundamental to preventive health care for women since the ability to control the timing and spacing of pregnancy directly relates to the health and well-being of women and their infants. Family planning services are low-cost and cost-effective, and include counseling on contraceptive techniques, prescribing or providing contraceptive supplies and/or insertion of contraceptive devices, and the screening and treatment of STDs.

For those considering a pregnancy, coverage should include a preconceptional health evaluation. This provision is extremely important because it provides an opportunity for counseling about important lifestyle and preventive issues to ensure a positive pregnancy outcome in the future. Studies indicate that women who maintain healthy lifestyles prior to conception typically give birth to healthier babies.

ACOG realizes it is critical to expand the basic benefits and other provisions of our proposal to include those essential for all Americans. Especially important for women are primary-preventive services such as Pap smears, mammograms, and counseling about health life styles. ACOG believes that health care for all Americans must be achieved in the near future.



In our view, health care reform should use and build on the strengths of the existing system, such as our multiple financing and delivery mechanisms. We believe an employer mandate would do this. Under ACOG's U.S. MaternaCare proposal, most women would continue to have maternity care services paid for by private insurance received through employment. Whatever path Congress decides to take to reshape our health care system, in our view any woman who does not have employer-provided insurance should be eligible for a government-sponsored program, regardless of income.

Further barriers to care, such as lack of transportation and the need for social services or health education, will remain — even when the goal of universal access is achieved. These remaining problems require continued and, in some cases, increased support for services organized and provided through the public health sector. In some communities, public health providers may also be the best organizations to coordinate the delivery of all services for underserved women and infants. ACOG strongly believes that Congress should remove these barriers to ensure access to care.

ACOG is eager to help the Health Subcommittee of the Ways and Means Committee determine the basic benefits that should be included in a health care reform package. Reform of our health care system is within our grasp, and ACOG applauds your involvement. Thank you for the opportunity to comment for the Subcommittee's Record.

## STATEMENT OF AMERICAN COUNSELING ASSOCIATION

The American Counseling Association (ACA) has a membership of nearly 60,000 professional counselors, and counselor educators who represent more than 200,000 of these practitioners across the country. Our members provide mental health, rehabilitation, substance abuse, employment, educational and other counseling services in a variety of settings including community mental health centers, hospitals, schools and universities, hospices, agencies for older Americans, private practice and other community based organizations. Professional counselors are at the front lines delivering counseling and mental health services to individuals, families and groups in need of such care.

Professional counselors have expertise that should be a part of the health care reform process. Because of our unique perspective and involvement with a continuum of mental health services, we can address health care reform from prevention and early intervention through acute and long term care. Professional counselors are recognized for increasing the availability of services in all geographic areas including rural as well as urban locations.

Regardless of work setting or area of specialization, mental health in health care reform and the consumer access issue are both issues that every professional counselor must address. Congress must pass legislation that ensures equitable mental health services within health care reform, comprehensive programs across the continuum of mental health services, and consumer access to all qualified mental health professionals, including professional counselors.

Three integral elements need to be included in health care reform to ensure that the mental health needs of consumers are met.

1. Access to a comprehensive continuum of mental health services-- prevention, early intervention, rehabilitation, acute and long-term care.
2. Cost containment uniformly administered.
3. Expanded list of authorized providers that will promote consumer choice of who provides services and how and where such services are provided.

### Access To A Comprehensive Continuum of Mental Health Services

ACA believes that mental health services should be available to all individuals as an integral part of a reformed health care system. The reformed health care system should ensure that individuals in need have access to a broad array of health and mental health treatment, rehabilitation, and prevention services emphasizing treatment in the least restrictive setting. These services should be delivered in an integrated and culturally sensitive way. ACA supports the services outlined in the enclosed document "Recommendations for Mental Health Services in Health Care Reform." ACA also agrees with the mental health community's call for individuals to be ensured access to the array of licensed or certified mental health professionals, including professional counselors, who provide these services.

Counselors emphasize mental health rather than mental illness. Promoting wellness and healthy life styles, and helping our clients achieve these goals distinguishes counselors from other mental health professionals. The medical model of mental health treatment relegates clients to being recipients of services rather than acknowledging them as participants. The counseling process empowers clients to make choices and emphasizes informed participation by clients.

Counselors embrace the concepts of prevention and early intervention, as well as remediation. They participate in the delivery of mental health services to individuals of all functioning levels, emphasizing the prevention and reduction of mental or emotional problems. By assisting clients to take responsibility for choices in behavior, counselors can address the issue of violence and socially destructive behaviors. Recognizing early warning signs and using effective early interventions can produce long-lasting positive results.

Young people experiencing interpersonal problems and academic problems compounded with family problems in the home are at high risk of dropping out of high school, becoming involved with drugs and crime or exhibiting violent behavior against themselves or others. By recognizing the early warning signs, a counselor can provide preventive services, appropriate interventions and support systems that enable these individuals to address their problems, and overcome circumstances that would have limited emotional development and their educational preparation. The cost saving in such a situation is truly immeasurable.

Prevention is a well accepted approach to improving physical health of individuals. ACA believes that any national health care plan must embrace this concept and extend it to include the prevention of mental as well as physical problems. The scope of prevention efforts is across the life span, from prenatal care and recognition of attachment needs of infants to fostering social networks and personal control for the elderly.

Literally, prevention means to keep something from happening. For mental health, it means intervening in a deliberate and positive way to counteract harmful circumstances before they cause disorder or disability or before existing disabilities become handicapping conditions. The potential of preventing mental and emotional disabilities is based on public health approaches of eliminating or modifying antecedent factors and of enhancing the individual's ability to tolerate

those factors. Prevention involves modifying risk factors or stressors, developing competence and ensuring support.

The situation presented above of early intervention with young people experiencing problems is only one example of prevention. Teaching a person with persistent mental illness how to cope with life's stressors and how to seek help before a crisis situation occurs is another example of prevention. Mental health counseling, case management, and rehabilitation counseling are all forms of prevention that have proven to be effective in preventing the need for psychiatric hospitalization and rehospitization.

Professional counselors offer interventions that equip people to deal successfully with the developmental issues that we all must face. Developing a person's ability to manage problems is a primary goal of counseling. Preventing a problem before it occurs or stopping a problem from escalating is important and cost effective in society.

### **Cost Containment**

Professional counselors are qualified to be serving as independent practitioners in providing quality and cost effective services under federal programs and to receive third party reimbursement from any system that evolves for the management of mental health care.

The need for mental health services has been well documented. According to the National Institute for Mental Health, almost one third of adults in the United States suffer from a mental disorder at some time in their lives. The Institute of Medicine has stated that at least 12 percent of American children (nearly 8 million) are also currently in need of mental health services.

ACA supports the position of the Coalition for Mental Health in Health Care Reform on the need for equitable mental health services in health care reform. Inability to pay for care is the most significant barrier preventing access to mental health services in the United States. Yet mental health care is treated differently than care for other health conditions in both public and private financing systems, often resulting in discrimination.

Mental illness knows no class, sex, race, or age limitations. Recent data provides a picture of the breadth and impact of mental illness in the United States, particularly among the working-age population.

- One in every 5 adults has a mental disorder: 41.2 million, excluding substance abuse disorders; 52.4 million including substance abuse disorders (1990).
- Mental illness is the third most disabling disorder, behind only cancer and stroke.
- People in their prime working years (25-44) accounted for the largest percentage of admissions to inpatient psychiatric services (1980).
- Suicide is the eighth leading cause of death and a potential outcome of mental illness and mental disorders.
- Many Americans report personal experience with mental illness and mental health professionals: 31% report they or someone in their family have, at some time in their lives, sought help of a psychiatrist or psychologist; 14% say they or someone close to them currently has a mental illness.
- One-third to one-half of younger individuals with severe mental illness also have substance abuse problems and at least 70% of substance-abusing youth have some type of concomitant psychiatric disorder.

### **Why Don't People Have Access to Mental Health Care?**

Thirty-seven million Americans have no health insurance; it is estimated that fifty million are underinsured. For the 153 million people who do have coverage, access is much more restricted for those seeking mental health services than for those with other health care needs. Mental health services are often not accessible because of gaps in coverage or inability to pay for treatment.

- Inpatient and outpatient benefits in private insurance for mental illness are far less comprehensive than those for physical illness—maximum benefits are lower, deductibles and co-insurance higher, and the percentage reimbursed substantially smaller.
- While 98% of persons with private health insurance had coverage in 1988 for outpatient mental health benefits, only 3% had mental health coverage equivalent to coverage for other illnesses. In general, many limits existed on the number of visits covered (36%), total dollars reimbursable (65%) and percentage of allowable charge paid (62%).
- Only a small percentage (10.7%) of all participants in health insurance were covered for partial hospitalization (day or night) treatment.
- Although 99% of insured individuals had private health coverage in 1986 for inpatient mental health treatment, only 37% had coverage equivalent to that for other illnesses. In general, many limits existed on the number of visits covered (36%), total dollars reimbursable (65%) and percentage of allowable charge paid (62%).



- In 1986, only half of adolescent outpatient visits to mental health settings were covered by commercial health insurance or Medicaid.
- Medical underwriting practices discriminate against persons in need of mental health treatment and those with a history of mental health treatment. Individuals who have received mental health care are often denied coverage altogether, and "mental disorder" is one of the most common conditions for which a medically underwritten group is rejected for coverage. This often leads to "job lock", as people are afraid to change jobs for fear of losing their health coverage.
- Many persons with insurance coverage pay for their mental health treatment out-of-pocket for fear they will be denied health insurance if they change jobs and their use of mental health insurance benefits is disclosed.

#### **What Does it Cost to Cover Mental Health Care?**

- In 1988, total expenditures for mental health care (excluding substance abuse) were estimated to be \$55.4 billion, and indirect costs (loss of productivity, etc.) were \$73.9 billion.
- The relative contribution of mental health hospital care to the total personal expenses for hospital care remained quite stable between 1980 and 1985, accounting for 10-11% of the total expense for hospital care. The relative contribution of mental health care for physician services remained stable over those five years, at about 3% of the total expense for physician care.
- Despite the fact that the relative contribution of expenditures for hospital care for mental illness remained stable, the source of these expenses shifted from state mental hospitals to scatter beds in general hospitals, thus becoming more visible costs, in terms of health care policy debates.
- Studies have shown relatively low rates of inpatient and outpatient utilization for mental health care. For example, a 1988 analysis using National medical Card Utilization and Expenditure Survey data found that 85% of all patients utilizing outpatient mental health services used 15 or fewer visits. Studies by the National Institute of Mental Health show similarly low rates of utilization for inpatient care.

#### **What Are The Costs of Failing to Provide Mental Health Care?**

- According to the Research Triangle Institute, American businesses lose over \$100 billion per year through lost productivity of employees due to substance abuse and mental illness.
- A four-year study (1985-88) of the McDonnell Douglas Corporation found that by offering mental health and substance abuse programs, the company will save \$5.1 billion over three years--\$2 million from reduced employee medical claims, \$2.3 million from reduced dependent medical claims and \$800,000 from reduced absenteeism.
- More than 70 studies published from 1967 to the present have demonstrated that improved access to mental health treatment actually results in reduced use of medical/surgical treatment which offsets the costs of mental health treatment.

#### **Expanded List Of Authorized Providers**

One way to facilitate consumers' access to qualified providers of mental health care is to expand the list of authorized providers within all federal legislation that provides programs of physical and mental health services and include clinical provider classifications from the mental health disciplines recognized in the Public Health Services Act, i.e. psychology, psychiatry, nursing, marital and family therapy, and social work. The profession of counseling is not currently included as a mental health discipline in the Public Health Services Act. This essentially denies consumers using federally funded programs the right of access to counselors as one of the largest groups of qualified providers of mental health services.

Professional counselors at the clinical level of practice provide professional counseling services by applying the principles of psychotherapy, counseling, learning theory, group dynamics and etiology of mental illness and dysfunctional behavior to treat individuals, couples, families, and groups for the purpose of treating psychopathology and promoting optimal mental health. While the perspective of professional counselors at the clinical level of practice is oriented toward diagnosis and treatment of mental and emotional disorders, training also focuses these counselors toward prevention and early intervention.

A significant percentage of mental health counselors at the clinical level of practice work in public and private mental health settings including community mental health centers, state agencies and facilities, hospitals, independent practice, etc. These counselors often work in underserved areas of the country--including rural areas and inner cities--and with underserved populations including Native Americans, older Americans, children and adults with severe mental illness, etc.



A recent study provides the first empirical data across mental health disciplines on certain clinical judgment tasks. Results support the recognition of certified mental health counselors as competent core providers of outpatient mental health services.

The ability to synthesize information about clients to form diagnoses and treatment plans is widely recognized as central to competent mental health service delivery. The American Mental Health Counselors Association has sponsored an ongoing research project since 1986 to study clinical judgment across mental health professionals.

Panels of 106 experts across six professions (psychiatry, social work, psychology, mental health counseling, marriage & family counseling, and psychiatric nursing) were drawn nationwide to develop standardized cases representing the two most commonly seen adult outpatient disorders. These experts developed criteria for case construction and treatment planning; scoring weights are based upon expert opinion regarding various aspects of treatment planning. Validation studies using these Clinical Treatment Planning Simulations (CTPS) found that the instruments demonstrate good content and discriminate validity.

A recent study using these instruments compared performance 232 experienced psychologists, social workers, and certified mental health counselors on two tasks: a case review of relevant client information, and treatment planning for this case. Results of this study reveal the following important findings:

1. Certified mental health counselors recorded the highest case review scores among the 3 professions across both disorders; this difference was significant compared to social workers for one disorder.
2. Certified mental health counselors recorded higher treatment planning scores than social workers for both disorders, and higher or comparable scores compared to psychologists on both disorders.
3. Participants who used Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) diagnoses recorded significantly higher case review scores than did those not using formal diagnoses, across both clinical disorders.
4. Participants using a structured format recorded significantly higher treatment planning scores across both disorders than those using unstructured treatment plans.

These findings provide the first empirically-based study across mental health disciplines on these clinical judgment tasks. Results support the recognition of certified mental health counselors as competent core providers of outpatient mental health services.

Budget cuts over the past decade have already had deleterious effects on both public and private mental health service systems. If mental health care is not afforded parity with physical health care in a national health care plan, counseling services now provided through federal, state, community, and private programs are in grave danger.

ACA supports Representative Kopetski's House Concurrent Resolution #52 and Senator Shelby's Senate Concurrent Resolution #16 calling for equitable mental health services within health care reform. These resolutions purport the need for both equity between mental and physical health services as well as a broad array of mental health and rehabilitation services including preventive counseling, crisis intervention, inpatient and residential treatment, and outpatient programs.

Consumers must be assured access to all qualified providers of mental health services, including professional counselors. The clinical training for professional counselors is comparable to training of other mental health disciplines. There are national board standards for professional counselors who wish to deliver clinical services as well as licensure in 39 states and the District of Columbia. Despite this, the profession of counseling is not currently included as a mental health discipline recognized in the Public Health Services Act (PHSA). This essentially denies consumers using federally or state funded programs the right of access to a large group of qualified providers of mental health services.

Counselor education programs are accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) and the Council on Rehabilitation Education (CORE). Approximately 60,000 professional counselors are licensed or certified in 39 states and the District of Columbia. Legislation is being pursued in the remaining states. In addition to state regulation of counseling, approximately 32,500 professional counselors are nationally credentialed as Certified Clinical Mental Health Counselors, Certified Rehabilitation Counselors, National Certified Counselors, and National Certified Gerontological Counselors.

## Summary

As a nation, we cannot deny access to mental health services. A growing body of evidence indicates that people who suffer from mental health disorders tend to be heavy consumers of medical care. Effective mental health care often saves money on the medical benefits. A wider range of qualified providers will provide consumer choice in selecting who, how and where such services are provided.

[Attachments have been retained in Committee files.]

**Joint Statement of**  
**HERBERT L. ROSEDALE, Esq., President, American Family Foundation, and**  
**PATRICIA E. RYAN, President, Cult Awareness Network,**  
**to the**  
**SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS**  
**U.S. HOUSE OF REPRESENTATIVES**  
**Hearing on Health Care Reform: Consideration of**  
**Benefits for Inclusion in a Standard Health Benefit Package**  
**March 30, 1993**

We submit this written statement to provide the Subcommittee and the record with information bearing on health needs, especially mental health needs, of former members of destructive cults, most of whom have no access to health insurance and few financial resources. At the outset, we want to thank Chairman Stark and the Subcommittee members for leadership in studying our nation's health care needs in order to rectify serious omissions and develop a standard health benefits package.

**Introduction**

Our statement on behalf of the American Family Foundation (AFF) and the Cult Awareness Network (CAN) briefly underscores the danger cults pose to children, summarizes some of the research literature relevant to understanding how people are harmed by a cult experience, identifies essential aspects of a health benefits package from the standpoint of ex-cultists, and reports on certain relevant international developments.

We are supplementing the statement submitted by our colleague, Dr. Margaret T. Singer, to the Subcommittee expressing her concern, shared by us and our colleagues at AFF and CAN, about how lack of medical insurance and financial resources prevents former cultists of all ages and family situations from obtaining assistance they so desperately need.

**AFF and CAN background**

The AFF is a tax-exempt research and education organization founded in 1979 to assist cult victims and their families through the study of cultic groups and their manipulative techniques of persuasion and control. AFF consists of a small professional staff and approximately 100 volunteer professionals, including psychiatrists, psychologists, social workers, educators, sociologists, physicians, attorneys, clergy, journalists, business executives, law enforcement officials, college and university administrators, and others who contribute to AFF's efforts in the areas of research, education, the law, and victim assistance.

CAN is the largest national non-profit organization which provides education and support services to the public on the cult issue. It was incorporated in 1978, the year the Jonestown tragedy occurred, and has 20 affiliates nationwide. It receives and responds to more than 16,000 inquiries annually concerning destructive cults and the problems they pose to society. CAN has established a support network, FOCUS, for former cult members. CAN's many supporters include mental health professionals, educators, clergy, law enforcement officials, ex-cult members and their families.

One of the reasons for Patricia Ryan's involvement in CAN is that my father, Congressman Leo J. Ryan, was assassinated in Jonestown, Guyana, while trying to assist followers of leader Jim Jones and their families who were victimized by that cult. Herbert Rosedale, attorney and partner in the firm of Parker, Chapin, Flateau & Klimpl, also serves as legal counsel for New York City's Jewish Community Relations Council Task Force on Cults and Missionaries and the Inter-faith Coalition for Concern About Cults.

**The Branch Davidians**

The unfortunate situation concerning the Branch Davidians in Waco, Texas underscores certain important facts about cults that should not be overlooked. First, the leader's psychological control over the group members can be so powerful that the group essentially becomes a projection of the leader's psyche. The future of David Koresh's followers depends upon how rational Mr. Koresh is with regard to the question of remaining alive. If he decides he does not want to live, the probability is that his followers will die with him. The dependency that cult leaders induce in their followers has grave consequences -- after leaving the cult as well as while in it.

**Risk to lives, health of children**

The second fact highlighted by the Waco situation is the risk cults often pose to the health, and sometimes even the lives, of children. Four features of cults tend to increase the risk to children: (1) Cults frequently live by an absolutist ideology that dictates harsh physical discipline

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and the rejection of professional medical care. (2) Cults' hierarchical structure and their setting themselves up as "family" frequently turn parents into "middle management" with regard to their own children, a subservient role that can become especially dangerous when the leader measures the parents' dedication by their willingness to abuse their children at his or her request. (3) Cults often are closed, physically isolated societies that resist any investigation of possible child abuse. (4) Cults that are religious in nature (some cults form around psychotherapists or political leaders) can further resist official scrutiny by invoking the First Amendment.

A survey of 70 former cult members (Gaines, Wilson, Redican, & Baffi (1984) reported, among other findings, that (a) 27% of the respondents said children in their groups were not immunized against common childhood diseases; (b) 60% said their groups permitted physical punishment of children; (c) 13% said that children were sometimes physically disabled or hurt to teach them a lesson; and (d) 13% said that the punishment of children was sometimes life-threatening or required a physician's care.

Although the murder/suicides of nearly 300 children in Jonestown stands as the most tragic example of cult abuse of children, many other tragedies have been reported. Consider as an example, the following quote from the medical report of a pediatrician who examined more than 50 children taken from the House of Judah after the death of a 12-year-old boy who was beaten to death for refusing to do his chores:

These nutritionally healthy bodies have been moderately to severely injured by repetitive beatings and other physical insults. Of the first 50-55 children examined by a physician after John's death a full 20% had signs of severe physical abuse. For the children greater than 5 years of age this percentage increases to approximately 40% and for boys in this age range, the figure is 70-75%. (Helfer, 1983, p. 253)

Additional examples of child abuse in cults will be discussed in a forthcoming volume, *Recovery From Cults*, edited by Michael D. Langone, Ph.D., Executive Director of the American Family Foundation. This book, which comprehensively examines the recovery needs of former cultists, is based upon research data, clinical reports, and the clinical experience of the book's contributors, "who collectively have worked with at least 9,000 cultists and their families, with the cult clinic of the New York Jewish Board of Family and Children's Services alone having helped more than four thousand individuals" (p. 17, draft copy).

#### **How cult experience harms people**

The limited number of formal research studies on harm related to the cult experience tend to support the views of clinicians such as Dr. Margaret Singer, who has already submitted a statement to the Subcommittee.

Otis (1985) examined data from a survey of 2,000 members of Transcendental Meditation (TM) in 1971. Dropouts reported significantly fewer adverse effects than experienced meditators, and "the number and severity of complaints were positively related to duration of meditation" (p. 41). There was a consistent pattern of adverse effects, including anxiety, confusion, frustration, and depression. The "data raise serious doubts about the innocuous nature of TM" (p. 46).

The Institute for Youth and Society (1980) in Bensheim, Germany reported that TM members tended to be withdrawn from their families (57% of subjects), isolated in social relations (51%), anxious (52%), depressed (45%), tired (63%), and exhibited a variety of physical problems, such as headaches and menstrual disorder.

Former members of a psychotherapy cult (Knight, 1986) reported that they had had sex with a therapist (25% of subjects), had been assigned to love mates (32%), had fewer than 6 hours sleep a night (59%), and in therapy sessions were shoved at least occasionally (82%), were hit at least occasionally (78%), and were verbally abused (97%). These subjects, 86% of whom felt harmed by the experience, also reported depression (50%) and menses cessation (32%).

In Conway et al. (1986) ex-members reported the following experiences during their time in the cult: sex with leaders (5%; 60% in the Children of God), menstrual dysfunction (22%), and physical punishment (20%). Conway and Siegelman (1982) reported that ex-members experienced floating (52% of subjects) [Floating refers to the experience of a disturbing shifting between cult and noncult modes of experiencing the world.], nightmares (40%), amnesia (21%), hallucinations and



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delusions (14%), inability to break mental rhythms of chanting (35%), violent outbursts (14%), and suicidal or self-destructive tendencies (21%).

Galanter, who studied 66 former Moonies, found that "36% of the respondents indicated the emergence of 'serious emotional problems' at some time after leaving the church; 24% had 'sought out professional help for emotional problems' after leaving; and 3% (i.e., two respondents) had been hospitalized for such problems during this interval" (1983, p. 985).

Langone et al. (in press), in a survey of 308 former cultists found that 88% of the subjects saw their groups as harmful (37%) or very harmful (51%). During an average time of membership of 6.7 years, 11% of the subjects reported being sexually abused. Sixty-eight percent of the subjects each knew an average of 28 former members who had not contacted helping resources. Thus, approximately 5,500 persons known to these subjects had not sought help. Yet 30% of subjects estimated that "all or nearly all" of their friends and acquaintances had difficulty adjusting to postgroup life and 21% felt that "most" had difficulty adjusting.

Martin, Langone, Dole, and Wiltrout (in press) used a variety of instruments, including the Millon Clinical Multiaxial Inventory (MCMI) to assess the psychological status of 111 former cultists. Martin et al. say:

This sample of ex-cultists can be characterized as having abnormal levels of distress in several of the personality and clinical symptom scales. Of those subjects completing the MCMI-I, 89% had BR's ["Base Rates" -- indicates the presence of a psychiatric disorder] of 75 or better on at least one of the first eight scales. Furthermore, 106 out of the 111 subjects (95%) who completed the MCMI at Time I had at least one BR score over 75 on one of the MCMI scales. The argument that this population of former cultists is indeed distressed is further buttressed by their mean score of 102 on the HSCL [Hopkins Symptom Check List], for which scores of 100 are considered to be indicative of the need for psychiatric care. Furthermore, previous research using the SBS-HP [Staff Burnout Scale] (Martin, 1983) found a mean of 48.75 (N=488, SD=18.61) for those involved in religious work...The current sample of ex-cultists had an SBS-HP mean of 72, which is more than one standard deviation above the mean of Martin (1983).

#### Essential aspects of health benefits package

Those who design a standard health benefit package need to be cognizant of the foregoing information regarding the physical and mental health harms suffered by children and others while they were members of such cults as well as the conditions in which they find themselves after exiting. It is extremely important to the well-being of these former cult members that there be programs to cover their emotional and mental rehabilitation needs, as well as continuing health needs of all kinds, including preventive, outpatient, and residential treatments. Such programs must include social work guidance that will help regressed, immature ex-cultists regain or develop an adult competence to manage day-to-day affairs. It is vital that helping professionals in these programs understand how cultic influence and control techniques affect ex-members of cults. Except in rare circumstances, ex-cultists need psychoeducational and social work help before they can benefit from traditional psychotherapy, should therapy be needed at all.

#### International dimension

We will close by saying a few words about the international dimension of the cult problem. In 1990 the American Family Foundation organized a meeting in Paris of representatives from 17 countries, including Japan, the United States, Canada, and most of the Western European nations. All of these countries had had similar experiences with cultic groups and the resultant formation of grassroots organizations to educate the public and help families and ex-cultists.

As a result of the Paris meeting, an international congress was planned for Barcelona. This congress, organized by the Catalan group, Asesoramiento e Informacion Sobre Sectas (AIS), with input from AFF, CAN, and other organizations, will take place from April 21 to April 24, 1993. Among the issues that will be addressed is that of the growth of cultic groups in Eastern Europe and the nations of the former Soviet Union. Indeed, colleagues in Europe have told us that representatives of cultic groups moved into Eastern Europe as soon as the Berlin Wall came down.

European governmental authorities have taken a number of steps to combat the cult problem. The European Parliament (West & Langone, 1986; Wilshire, 1990), the Council of Europe (The



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Council of Europe's Report, 1992), the government of Israel (State of Israel Report, 1989), and the Vatican (Sects or New Religious Movements, 1986) have all published reports that have been reprinted in AFF's *Cultic Studies Journal*. The governments of at least seven countries, but not the United States, have contributed funds to cult educational and research organizations.

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## STATEMENT OF THE AMERICAN FOUNDATION FOR THE BLIND

This statement is submitted for the record on behalf of the American Foundation for the Blind relative to the Subcommittee's March 30, 1993 hearing on basic health care benefits. The mission of the American Foundation for the Blind is to enable persons who are blind or visually impaired to achieve equality of access and opportunity that will ensure freedom of choice in their lives. AFB accomplishes this mission by taking a national leadership role in the development and implementation of public policy and legislation, informational and educational programs, diversified products, and quality services.

According to the most recent estimates of the American Foundation for the Blind, approximately 4.3 million individuals in the United States are totally blind or are severely visually impaired.

Blind or visually impaired people have special needs such as vision-related services and associated assistive technology in addition to a full array of services including preventive services, prescription drugs, and diagnostic services which will benefit all Americans. Vision-related services and associated assistive technology are designed to prevent the further loss of vision or restore the functional ability of persons who have lost their vision. These services and devices include the following:

- preventive services including regular vision screening and other medical/surgical intervention to prevent the worsening of a vision-related condition;
- low vision examinations provided by optometrists or ophthalmologists and devices designed to maximize remaining visual functioning;
- instruction in use of the long white cane or other mobility devices. These services are best provided by orientation and mobility specialists who work primarily with people who are blind or visually impaired;
- instruction in the skills of daily living including braille, personal care, and household management (cooking, cleaning, etc.). These services are best provided by rehabilitation teachers of the blind or visually impaired;
- training in, and acquisition of, assistive technologies such as talking glucose monitoring equipment, talking computers, notetakers, and other equipment (such as electronic braille display devices). These training services are provided by rehabilitation engineers or assistive technology specialists;
- personal assistance services (including the assistance of a reader).

Unlike other therapies or durable medical equipment, vision-related services and assistive technology are not looked upon as medical services and are usually not prescribed by physicians, even though they serve the same purpose as other restorative therapies. Specially trained professionals such as Orientation and Mobility specialists and Rehabilitation Teachers provide one-on-one instruction to blind or visually impaired persons. Services can be provided at the client's home or as part of a day or residential rehabilitation program. Orientation and Mobility specialists who are certified by a national professional organization, usually possess at least a bachelor's degree, and are qualified to teach the use of the long white cane and other orientation and wayfinding techniques. Similarly, rehabilitation teachers, who provide a broad range of instruction in the skills of daily living, are also certified professionals who must meet certain degree and performance standards.

Generally, Medicare, Medicaid, or private insurance do not currently reimburse the cost of vision-related services and devices while other restorative services and devices, which may be needed by a stroke patient or amputee (such as occupational therapy and prostheses), are covered. Because such services are not regarded as therapies and are not usually provided under the supervision of a physician, Orientation and Mobility services and Rehabilitation Teaching services are generally not reimbursed. Exceptions to this general rule include:

- some low vision examinations provided by ophthalmologists;
- orientation and mobility or rehabilitation teaching services provided by occupational therapists or physiotherapists under the direction of a physician. Occupational therapists and physiotherapists do not possess the same level of training or experience in the needs of people who are blind or visually impaired, and most often provide their services through a hospital-based program or other comprehensive health care

facility. Finally, the Medicaid program will reimburse for many of these services for children who are found eligible under the Early Periodic Screening Diagnostic and Treatment Program where such a program is in effect.

The cost of these services and devices depends upon the particular needs of the individual in question. The cost for orientation and mobility services varies greatly depending upon whether such services are provided on a stand-alone basis or as part of a comprehensive rehabilitation program. Costs also vary depending upon the existence of multiple disabilities and upon whether services are provided in a community setting or as part of a residential program. The time required and costs can range from a low figure of approximately 10 hours at about \$65 per hour to provide very basic orientation and mobility skills to approximately \$275 per day for six weeks for a more comprehensive program. The cost of a residential program would be higher. The cost for rehabilitation teaching is roughly comparable. Once again, depending upon the needs of the individual, the cost of assistive technology varies from a few dollars for "low tech" items such as hand-held magnifiers to as much as \$1,000 to \$20,000 for more sophisticated electronic items.

These services and devices provide greater independence to the individual and his/her family and a significant increase in quality of life. Mobility and skills of daily living help prevent institutionalization of older blind persons and substantially prolong the independence of such individuals in their own homes and communities.

## AMERICAN SOCIETY OF CLINICAL ONCOLOGY

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The American Society of Clinical Oncology (ASCO), representing some 9,000 physicians engaged in clinical practice and research, looks to the national debate on health care reform as a forum to address many long-standing problems facing cancer patients and survivors. We thank you, Mr. Stark, and the Committee on Ways and Means for the opportunity to highlight these issues which have such a significant impact on people with cancer.

Clearly, the country is beginning to accept the challenge of reforming our health care system. The economic recovery of the country as a whole and the welfare of individual citizens are viewed by many as dependent on substantial reform of both health care delivery and third-party payment. However, as we address these goals of expanding access and restraining costs, the cancer community is concerned that the reforms we adopt maintain quality of care. Health care reform will only be successful to the extent it achieves a balance among these three factors -- access, cost-control, and quality.

**Impact on Cancer Patients**

Each year, over 1 million Americans will be diagnosed with, and 500,000 people will die from, cancer. Fifty percent of these diagnoses occur in people over the age of 65. Soon cancer will overtake heart disease as the leading cause of death. By the end of this decade, cancer will account for more than 20 percent of health care expenditures.

In light of these statistics, perhaps it is not surprising that cancer treatment is often regarded as inherently not cost-effective and thus a favored target for restraining either the scope of services or payment amounts for those services. Yet, we must not lose sight of the fact that cancer therapy -- whether curative or palliative -- is improving. In recent years, the overall relative five-year cancer survival rate has improved from 38 to 52 percent.

Health care reform must recognize the needs of the 8 million Americans now living as cancer survivors. People with cancer suffer disproportionately from the deficiencies in the present health care system. The problems encountered by those currently or formerly diagnosed with cancer include:

- discrimination on the basis of health status against individuals diagnosed with cancer or their family members to prevent them from obtaining insurance;
- use of preexisting condition clauses to restrict unfairly the extent of coverage for those able to purchase insurance;
- pricing policies for insurance based on experience rating rather than community rating, which unfairly penalizes small groups and subjects people with cancer to potential job discrimination;



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- exposure to catastrophic out-of-pocket expenses because insurance coverage is inadequate; and
- arbitrary denial of coverage for cancer treatment involving either unlabeled indications of drugs approved by the Food and Drug Administration (FDA) or investigational therapy given pursuant to a clinical trial.

Virtually any approach to reform likely to receive serious consideration will address many of these problems, including discrimination, preexisting conditions, pricing and rating practices, and maximum out-of-pocket expenditures. However, there is not cause for similar optimism concerning the nature and extent of coverage for cancer treatment to be offered in any reform proposal.

#### Considerations for Health Care Reform

In a reformed system, benefits for cancer treatment must be at least as comprehensive as those in the Medicare program. This includes coverage for services (including drugs used as part of an anticancer regimen) provided incident to a physician service. However, to ensure access to high quality care, these benefits must be expanded to include explicit coverage for drugs prescribed for indications not specified on the Food and Drug Administration (FDA) label as well as for patient care costs associated with participation in clinical trials. Optimally, coverage should also be extended to outpatient drugs, prevention services including health education, and diagnostic screening for diseases like cancer that are more readily treatable if diagnosed early.

Furthermore, the reformed system must ensure every individual with cancer access to a trained oncologist or other specialist in the treatment of that disease. To the extent that managed care is part of the health care reform solution, every plan should be required to provide adequate oncology and other specialty services.

#### Unlabeled Indications of FDA-Approved Drugs

Modern oncologic practice requires the frequent use of drugs for indications other than those specifically approved by FDA. Somewhere between one-half and three-fourths of the uses for anticancer drugs involve these so-called unlabeled indications. Oncologists inform themselves of the best treatment for their patients not by consulting the drug labeling endorsed by FDA, but by reference to standard medical compendia and to the medical literature, which in the field of oncology is constantly being updated to recognize new therapies based on existing anticancer agents.

FDA itself has always recognized the physician's prerogative to use approved drugs in ways other than contemplated on the label. In a 1982 Drug Bulletin, FDA stated that the Food, Drug & Cosmetic Act "does not...limit the manner in which a physician may use an approved drug." Moreover, "[once] a product has been approved for marketing," according to the agency, "a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling." This view has been supported by the Health Care Financing Administration (HCFA), the National Cancer Institute (NCI), and the Institute of Medicine as well as national representatives of

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the insurance industry.

Coverage for unlabeled indications was studied extensively by the National Committee to Review Current Procedures for New Drugs for Cancer and AIDS (the "Lasagna Committee"), appointed by then Vice President Bush. The Committee recommended coverage of unlabeled indications where such uses are listed in one of the three medical compendia<sup>1</sup> or otherwise supported by the medical literature.

In response to the Lasagna Committee report, both the Health Insurance Association of America and the Blue Cross/Blue Shield Association have liberalized their positions on this issue. In addition, the Medicare program has long pursued a policy, as reflected in the Medicare Carriers Manual, of permitting coverage of unlabeled indications, particularly in the area of cancer treatment. Yet, despite what appeared to be consensus regarding coverage of unlabeled indications, many private insurers as well as several Medicare carriers have refused payment for unlabeled indications on the spurious ground that such uses are "experimental," "investigational," or "not acceptable medical practice."

Lack of standard coverage for unlabeled indications of drugs used as part of an anticancer regimen has severe negative consequences for patients and physicians alike:

- First, patients are deprived of the best available care, which often involves use of unlabeled indications.
- Second, refusal to cover unlabeled indications inhibits dissemination of new therapies which not only may improve the patient's chance for survival but also pave the way for future advances.
- Third, at least some opportunities for cost savings are lost when carriers refuse to pay for new products or new indications which may in fact be more cost-effective than older alternatives.
- Fourth, physician and office resources are wasted when unlabeled indications which should be routinely reimbursed require substantial effort to have payment recognized.
- Fifth, drugs represent a significant out-of-pocket expense for both patients and physicians, so that nonpayment for them is more problematic than a simple refusal to cover other physician services.

Several recent studies conducted by the General Accounting Office (GAO) have demonstrated the severity of this problem. In September 1991, GAO released the results of a national survey concerning reimbursement for unlabeled indications.<sup>2</sup> More than half of the respondents indicated

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<sup>1</sup> American Hospital Formulary Service, U.S. Pharmacopeia -- Dispensing Information, and the American Medical Association Drug Evaluation.

<sup>2</sup> In February 1991, initial results of the survey were published.

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reimbursement problems during the previous twelve-month period in connection with use of an anticancer drug for an unlabeled indication.

A follow-up study, requested by the Senate Finance Committee, was published in July 1992. In this survey, GAO examined the impact of reimbursement decisions on the setting and cost of chemotherapy administration. GAO observed that some patients are receiving care in hospital settings when, by clinical standards, treatment could have been provided in the office and that financial factors are influencing the choice of treatment setting. GAO concluded that Medicare reimbursement policies for unlabeled indications may negatively affect "where a cancer patient gets treatment and, as a result, Medicare costs for that patient's care."

To resolve this problem, carrier discretion in this area must be curtailed and national policy adopted to ensure all cancer patients access to state-of-the-art treatment. This policy must affirmatively require carriers to reimburse unlabeled indications of FDA-approved agents when such uses are referenced in one of the three authoritative medical compendia or otherwise supported in the peer-reviewed medical literature.

#### **Patient Care Provided in Clinical Trials**

Substantial progress in treating cancer has been made over the course of the past two decades through clinical research. Patient enrollment in clinical trials not only enables this progress to continue, but also provides access to the best available care to people with cancer. In recent years, however, many third-party payers -- including the Medicare program -- have targeted clinical research as a means of controlling costs. Many insurers will deny coverage for patient care costs involved in clinical trials even though the care is probably superior to that which would have been received off protocol, particularly in the treatment of cancer.

A January 1989 report<sup>3</sup> submitted to the Senate Appropriations Committee by the National Institutes of Health emphasizes this point:

"NCI does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered...For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."

<sup>3</sup>

Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute. January 1989. (Report submitted to the Senate Committee on Appropriations in response to Senate Report No. 100-399.)

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It is critical that any health care reform proposal include, as part of the minimum benefits requirement, provision for reimbursement in connection with care provided in clinical trials. By doing so, a reformed health care system can encourage advances in medicine and evaluate the relative outcome and effectiveness of treatments. At the same time, this coverage policy would allow desperately ill patients access to optimal care, regardless of their ability to pay.

To ensure access to high quality cancer care, the cost of medical care provided when a patient is entered on a Phase I, II, III, or IV (post-marketing) clinical trial -- including hospital, physician, and other health care services as well as the cost of approved agents for labeled or unlabeled uses which might be part of the regimen -- should not be denied coverage and reimbursement when all of the following are demonstrated:

- Treatment is provided with a therapeutic intent;
- Treatment is being provided pursuant to a clinical trial which has been approved by the National Cancer Institute (NCI), any of its cancer centers, cooperative groups or community clinical oncology programs; the Food and Drug Administration in the form of an investigational new drug (IND) exemption; the Department of Veterans Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;
- The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training;
- There is no clearly superior, noninvestigational alternative to the protocol treatment; and
- The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the alternative.

Coverage policy based on these standards would strike an appropriate balance for any third-party payment system because it recognizes that therapy which has not been definitively established as the standard of care should be reimbursed only in a carefully controlled context where ethics, potential effectiveness, and contribution to medical progress are taken into account. This position is supported not only by the physician and research community but also by patients and survivors of cancer as represented by the National Coalition for Cancer Survivorship (NCCS), the largest nationwide consumer group speaking on behalf of people with all kinds of cancer.

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The debate on health care reform has, to date, centered on access and cost-containment. While these factors are essential, attention must also be given to the impact of a new system on our ability to deliver the best available care. Cancer



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patients and others with serious and life-threatening diseases deserve access to state-of-the-art treatment. We can greatly facilitate achievement of this goal -- as well as improve our ability to assess relative effectiveness of therapies -- by adopting national, uniform coverage policies for unlabeled indications of drugs used in an anticancer regimen and for patient care costs associated with clinical trials. Any system which omits these as minimum benefits will disproportionately deny cancer patients access to high quality care.

**STATEMENT OF ARTHUR GRAYZEL, M.D., VICE PRESIDENT, MEDICAL  
AFFAIRS, ARTHRITIS FOUNDATION**

On behalf of the Arthritis Foundation, which represents 37 million Americans with arthritis, I am pleased to provide the subcommittee with this statement regarding our views on a standard benefit package in any health care reform plan.

The Foundation is deeply concerned about access to health care for people with arthritis and other chronic diseases. We believe the goal of access to total care includes all the services necessary to preserve health, prevent loss of function, and maintain the highest possible quality of life.

Arthritic and rheumatic disorders are among the most prevalent of all chronic illnesses and a major cause of disabling limitations. The Foundation estimates that as many as 3 million Americans with arthritis cannot do every day tasks such as dressing or bathing because of the disabling affects of the disease and that arthritis costs the U.S. economy an estimated \$35 billion per year in medical care and lost wages. As the population ages, people with chronic diseases will represent a growing percentage of this nation. It is critical that any health care reform plan address the needs of people with chronic diseases now rather than later.

Optimum care for these diseases requires a coordinated team approach that utilizes a variety of health and social services to manage these illnesses and minimize disability. For reasons outlined in the following, many of the 37 million Americans who have arthritis and other rheumatic diseases do not have adequate access to this type of care.

The Arthritis Foundation has adopted a statement on **Reforming Access to Health Care** which lists the elements we believe any national health plan should contain in order to adequately meet the needs of out-patients. A copy of this document is attached for your review and consideration.

People with chronic diseases like arthritis need access to care at the earliest stages of the disease and, in many cases, on a long-term and frequent basis. Moreover, we believe that research is the first step to prevention and reducing our health care costs. Any new health care system must incorporate our nation's medical research efforts into the system. Finding new and better therapies and a cure would, in the long run, save the health care system and the economy money and improve the quality of life for many people.

Until a cure is found and we can identify how to prevent all arthritic diseases, we need to provide a continuum of care for people with arthritis, including services necessary for diagnosis, treatment, and rehabilitation. The Foundation supports health care that emphasizes functional ability to enable people with arthritis to remain employed and perform the activities of daily life—not just acute care provided in a hospital setting.

Elements of a standard benefits package should include:

- \* outpatient physician services
- \* referral for specialized care
- \* prevention and patient education
- \* rehabilitation services like physical, occupational and vocational therapy
- \* assistive devices used for safety, to relieve pain, and to improve functional level
- \* prescription and other drugs
- \* laboratory and other monitoring procedures to ensure the safety of medical interventions
- \* surgery to relieve pain and promote mobility
- \* long term care

We believe that any national health plan must address some fundamental needs including access to health care providers who can effectively manage and provide quality of care to patients with arthritis and employment-based health insurance that guarantees transferability and does not contain pre-existing conditions. These last guarantees must apply to any supplemental insurance as well as to the standard basic benefit. Finally, the Arthritis Foundation strongly supports a health care system that incorporates and recognizes the value of increased research in the search for a cure.

The Arthritis Foundation stands ready to supply any information, data, and supporting materials that you may require in your efforts to produce legislation and define a standard benefit package. We believe that Congress should write into law what will be included in a standard benefits package. We do not want any Board or other entity to determine what may be in and what may be out of any plan.

In closing, we believe that every American has the right to affordable, accessible, cost-effective and quality health care. We also believe that every American has an obligation to maintain his or her own well-being and use the health care system wisely. We are committed to educating the public, and to the passage of any health care legislation that addresses the needs of people with chronic diseases like arthritis.



March, 1992

## REFORMING ACCESS TO HEALTH CARE

The Arthritis Foundation is a national, voluntary health organization with 71 chapters throughout the United States working to improve the quality of life for the 37 million Americans with arthritis. The Arthritis Foundation is actively participating in the current debate over health-care reform on behalf of people with arthritis.

The Arthritis Foundation will work to develop a national health plan that will provide the services and quality of care needed by people with arthritis.

**The Arthritis Foundation believes:**

- All Americans should have access to health care.
- Employment-based health insurance should include safeguards to protect the interests of people with arthritis, who have a high rate of job-loss caused by disability. No one should be denied insurance coverage on the basis of a pre-existing condition, and convertibility and transferability of existing policies should be guaranteed.
- A continuum of care for people with arthritis should be provided, including services necessary for diagnosis, treatment, and rehabilitation. The Arthritis Foundation supports health care that emphasizes functional ability, to enable people with arthritis to remain employed and perform the activities of daily life — not just acute care provided in a hospital setting.

Elements of a plan should include, but are not limited to:

- \* outpatient physician services
- \* referral for specialized care
- \* prevention and patient education
- \* rehabilitation services like physical, occupational, and vocational therapy
- \* assistive devices used for safety, to relieve pain, and to improve functional level
- \* prescription and other drugs
- \* laboratory and other monitoring procedures to ensure the safety of medical interventions
- \* surgery to relieve pain and promote mobility
- \* longterm care

(over)

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- Quality of care must be assured. Quality assurance activities such as the development of outcomes information and/or "effectiveness research" need to be strengthened and incorporated into any health-care reform initiative.
- Cost-containment measures that would control the overall health expenditures should be incorporated into all reform proposals. Such measures include: decreasing administrative costs, initiating malpractice and liability reforms, and creating incentives to test and evaluate new delivery systems.
- Increased research will yield cost savings. Finding the cure for arthritis and other chronic diseases is the ultimate prevention measure.

**ACTION:**

The Arthritis Foundation believes every American has the right to affordable, accessible, and cost-effective quality medical care. It urges that any health-care legislation address the needs listed above.

APPROVED BY THE BOARD OF TRUSTEES

April 1992

April 27, 1993

The Honorable Janice Mays  
Chief Counsel and Staff Director  
Committee on Ways & Means  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington, DC 20515

Re: Health Care Reform: Consideration of benefits for inclusion in a  
Standard Health Benefit Package.

Dear Congresswoman Mays:

Standardization of healthcare procedure (dental, surgical, optical, etc.) cost is necessary if the United States is to economically, and fiscally manage the health benefit system.

Standardized Healthcare Procedure Cost (SHPC) is a concept whereby healthcare procedure supplies, for a specific procedure such as a teeth cleaning (prophylaxis) or appendectomy, are in kit form. The correct type and quantity of all the required procedure's supplies are provided and therefore the standard cost of the procedure supplies is established. Since the procedure kit is already assembled and ready for use, a labor savings is also realized.

In the majority of instances, these supplies would be sterile.

For example, a typical teeth cleaning (prophylaxis) procedure would require the following sterile components:

- instruments (6)
- gauze (20 pcs.)
- cotton rolls (2)
- patient bib (1)
- latex gloves (1 pr.)
- face mask (1)
- prophylaxis angle (1)
- prophylaxis paste (1)
- saliva ejector (1)
- suction tube (1)
- tray and lid (1)

These supplies would be in sterile kit form, ready for use on a patient.

The vast majority of hospitals customize rather than standardize procedure kits. However, the custom nature of the kits drives up the manufacturers costs thus negating the possibilities of minimized standardized procedure costs.

This healthcare procedure concept not only quantifies procedure cost but also complements government efforts to improve infection control, and reduce the risk of infectious disease transmission to healthcare workers and patients (29 CFR 1910.1030 Occupational Exposure to Bloodborne Pathogens).

In February of 1993, Aseptic Dental Technologies, Inc. of Lincolnshire, Illinois introduced this kit concept to dentistry.

Not only does this concept quantify and make known the supply cost of dental procedure but also helps reduce the overall cost of dental care.

The Honorable Janice Mays  
 April 27, 1993  
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The kits are delivered to dental offices in sterile form ready for use, and provides the following cost reduction features:

- reduced labor cost of procedure set-up,
- elimination of the need for the dental office to wash, disinfect, bag, sterilize and sharpen dental instruments,
- increased dental offices capacity to treat more patients daily,
- reduced labor cost of ordering supplies, inventory management, and overall office clean-up procedure.

This ADT kit concept provides up to a 50% cost reduction for the typical dental procedure (ADA study 1991).

ADT's sterile procedure kit reduces the dental office liability relating to sterilization, and employee/patient infection control.

ADT assumes liability for sterilization. The dental office no longer needs to attempt to sterilize hand instruments in-office.

ADT provides all the procedure supplies in sterile form, whereas today, the dental profession itself cannot reproduce this sterile feature.

Compliance with OSHA law 29 CFR 1910-1030 is further insured since the dental professional no longer is exposed to the risks associated with the scrubbing, washing, sharpening and sterilization and, therefore, realizes reduced cost of labor.

One other comment on Law 29 CFR 1910.1030 is that it has resulted in increased costs to healthcare professionals.

The law requires the use of personal protective equipment for all employees who potentially come in contact with infectious materials (body fluids, bloody supplies, etc.)

Some companies have reported 50-100% sales increases relating to personal protection equipment (gloves, masks, goggles, gowns, etc.). 85% of healthcare professionals polled stated they expect the new OSHA law to result in an increase in their spending on supplies (reference Hospital Purchasing News, April 1992).

The Aseptic Dental Technologies, Inc. sterile dental kits greatly reduces the need of this expenditure to dental professionals since the office employee is no longer exposed to the risk of handling, cleaning, scrubbing, sharpening, packaging and sterilizing bloody, contaminated instruments. Hence there is a greatly reduced need for additional personal protective equipment.

Standardized health care procedure kits can greatly contribute to the control of health care costs.

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They provide new product opportunity for companies who wish to manufacture these kits. They create jobs.

Companies who wish to manufacture these kits would be regulated by the Food and Drug Administration as medical device companies.

Aseptic Dental Technologies, Inc. regretfully apologizes for the brevity of our comments, but our knowledge of this opportunity to provide written testimony was received April 27.

Highest regards,

A handwritten signature in cursive script, reading "Bruce J. Schullo".

Bruce J. Schullo  
Director, Vice President  
Aseptic Dental Technologies, Inc.  
600 Heathrow Drive  
Lincolnshire, IL 60069

[Attachment to the statement has been retained in the Committee files.]



## **STATEMENT OF ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND NEONATAL NURSES**

Thank you for the opportunity to present testimony before the subcommittee. The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), formerly NAACOG, is a nonprofit association of professionals dedicated to establishing and promoting the highest standards of perinatal and women's health nursing practice, education, and research. The organization's nearly 30,000 members represent a rich diversity of skills and experience united in the common cause of promoting optimal health care for women, infants and their families. AWHONN members practice in hospitals, clinics, offices, academia, and the military services.

AWHONN welcomes the opportunity to comment on the essential services that we feel should be included in the health care reform comprehensive benefit package. AWHONN encourages the development of a comprehensive package that includes primary and preventative services for women. Fifty two percent of the population are women and they are major consumers of health care services.

It is important to remember that health care is not just treatment of illness but includes prevention and early detection. If there is to be control of escalating health care costs, we believe there should be a shift in health care towards a system of health promotion and disease prevention services. This revised system of care must be adequately defined in the comprehensive benefit package.

### **PRIMARY AND PREVENTATIVE CARE FOR PREGNANT WOMEN AND INFANTS**

Statistics regarding the health status of Americans, in particular our children, continue to be embarrassing. The United States ranks nineteenth among thirty-three industrialized countries in preventing infant deaths behind nations such as Hong Kong, Singapore and Ireland. A White House Task Force on Infant Mortality determined in 1989 that one in four of all American infant deaths and disabilities is fully preventable when comprehensive prenatal care begins in the first trimester.

Prenatal care can not only decrease the human costs of suffering but financial costs of health care as well. A study by the Institute of Medicine found that for every dollar spent for prenatal care, three dollars and thirty eight cents is saved in medical care for low birth weight infants.

In addition, 60 percent of women experience complications during the prenatal or intrapartum periods. These complications have been reduced when appropriate and timely maternity care is received.

It is essential that a full range of services for mothers and their children be included in the comprehensive benefits package. Services must include prenatal, intrapartum and postnatal care, coverage of preventative health exams for infants and children, immunizations and treatment of both routine and chronic illness and conditions of infancy and childhood.

### **PRIMARY AND PREVENTATIVE WOMEN'S HEALTH CARE SERVICES**

The need for reproductive health services continues over the course of a women's life beyond the childbearing years. The benefits package must contain preventative health services such as routine gynecological histories and exams, clinical breast exams, pelvic exams, and screening for and counseling about sexually transmitted diseases.

Studies have suggested that regular breast exams and mammography screening will reduce breast cancer death rates by thirty percent. The survival rate for women with cervical cancer diagnosed in the early stages via pap smears is near 100%.

Since women with HIV are the fastest growing segment of our AIDS population and women are susceptible to many other sexually transmitted diseases that do not present clear symptoms to alert them, routine screening and counseling are needed to assure early detection and reduce long term costs. A study done by the Centers for Disease Control and Prevention found that a frequently sexually transmitted disease, chlamydia, can be reduced by as much as 51% if screening by health care professionals is routinely done.

Other essential reproductive services that must be considered are family planning and infertility services. The need for family planning services in the United States is extensive for there are nearly 60 million women in their childbearing years. Infertility affects one in twelve couples in the United States and is a major cause of depression in women. The majority of infertile couples can be treated with low cost conventional methods that do not require expensive and ethically debatable reproductive technologies.

Other health care issues routinely confront women such as osteoporosis, mental illness, and menopause. These conditions can be best managed by primary and preventive therapy, health counseling and pharmaceutical intervention.

Osteoporosis affects 50% of women over the age of 45 and 90% of women over 75. This disease process within the bones results in 1.3 million fractures a year and over 50,000 deaths. Preventative care can reduce future costs associated with this potentially progressive disease.

Depression is twice as likely to occur in women than in men and the majority of eating disorders associated with poor self image occur in women. Over 20% of health care visits today are related to mental health problems. Routine screening of women would help detect mental illness in its earliest stages.

Menopause is not a medical condition, however this normal aging process is associated with a variety of clinical symptoms: hot flashes, urinary tract and vaginal changes, as well as changes in bone mass and mental attitude. Early intervention and counseling can prevent future complications from arising and contain health care costs.

#### **HEALTH CARE SETTINGS AND PROVIDERS**

Although the development of a comprehensive benefit package is an essential aspect of health care reform, access to needed care is another important component. The delivery of primary, preventive and long term health care must be done in settings that are convenient and offer a wide spectrum of available services. In addition to doctor's offices and hospitals, logical places to provide services include schools, work places, day care centers, homes, and community based centers such as Community Health, Rural Health and Migrant Health Centers.

Long term care is especially important for women because they are usually the primary care giver for their husbands and others within the home setting. Since women often live longer than their spouses, they are more likely to require the services of a nursing home. Given the ongoing debate on the prohibitive costs associated with long term care, AWHONN calls for consideration of minimal long term care services provided within the home and community settings to be included in the comprehensive benefit package.

With the restructuring of the health care system, women should have the option of choosing their health care provider. In the past, providers other than physicians have not been fully utilized because of financial, professional and legal barriers. Two decades of research on advanced nursing practice is summarized in the Yale Journal on Regulation and shows that advanced nurse practitioners

can safely provide 90% of primary care needed by children and 80% of primary care required by adults.

A study done by the Office of Technology Assessment shows the care provided by advanced nurse practitioners is of comparable quality and lower cost than physicians provide. Nurses prescribe fewer drugs, use fewer tests, choose less expensive treatments and spend more time on patient education and counseling.

International comparisons show that at least 75% of all prenatal care and delivery of babies could be provided safely by certified nurse midwives however, nurses deliver less than 4% of all babies in the United States.

#### **COVERAGE ISSUES**

Estimates of the number of uninsured women in the United States range from 16-17 million. Too often, employer policies no longer cover spouses and many small businesses which traditionally employ women do not offer health insurance benefits. Thirty one percent of women say medical costs have prevented them from getting medical care. In many cases, health insurance does not provide coverage for health care services such as family planning, prevention or mental health. In 1985, 26% of women in their childbearing years had no insurance for maternity care and 15% had no insurance at the time of delivery.

AWHONN encourages universal access to a national standard package of services that will address women's health needs. Currently, coverage of women's health care services varies. As discussions regarding a newly designed health care system includes the formation of accountable health plans (AHPS) and negotiations between providers and insurers, it is imperative that coverage decisions are not left to the discretion of the individuals AHPS. This would lead to inequitable coverage of services for women in different parts of the country.

AWHONN demands equitable treatment for all women in the health care system and encourages the dissemination of information to consumers so they will be able to make informed health care decisions.

By providing a comprehensive set of benefits that include primary and preventative services, quality health care can be afforded to all in need. If the United States is to overcome its own embarrassing health status statistics, we must all rethink how health care should be delivered and financed. We are now at a crossroads. Failure to do nothing will only result in increased costs, poorer health status, and impact on the future competitiveness of this country.

AWHONN is eager to work with the Congress in improving the U.S. health care system. We thank you for the opportunity to express our views.





## Association of World Academics for Religious Education

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Statement of JAMES R. LEWIS, Ph.D.  
Academic Director, A.W.A.R.E.  
TO THE SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
April 30, 1993

The Association of World Academics for Religious Education (AWARE) is an association of mainstream scholars who have joined together to propagate objective, accurate information about non-traditional religious groups (often pejoratively referred to as "cults"). It has come to our attention that representatives of the Cult Awareness Network (CAN) and the American Family Foundation (AFF), in tandem with Dr. Margaret Singer, have issued statements to this committee--statements that impute special health needs to current and former members of alternative religions. These documents are flawed on several points. Their fundamental error is that non-traditional religions are stereotyped as pseudo-religions, all more or less guilty of abusing their members. Mainstream scholars have, however, found such stereotypes to be inaccurate. The great majority of alternative religions are spiritually authentic, psychologically healthy organizations whose chief "crime" is that their beliefs and practices diverge significantly from our society's religious and cultural traditions. To collapse distinctions within this complex spectrum and imply that all such religions are potential Jonestowns/Branch Davidians is inaccurate and misleading.

The CAN/AFF and Singer statements also create the impression that they represent the mainstream of professional/scholarly opinion. Singer's theories have, however, been explicitly rejected by the American Psychological Association. Thus Singer and the other professionals alluded to in CAN/AFF statement represent a minority opinion within the larger community of professionals. The mainstream of scholarly opinion is that most alternative religions do not represent any special health concern. AWARE urges the subcommittee not to divert its energies into this controversial area.



John D. Golenski, Ed.D.  
 President  
 Bioethics Consultation Group

## CONSIDERATION OF BENEFITS FOR INCLUSION IN A HEALTH BENEFITS PACKAGE

Thank you for the opportunity to offer written testimony before the Subcommittee on Health, Committee on Ways and Means on Health Care Reform. My name is John Golenski, Ed.D., the President of the Bioethics Consultation Group, of Berkeley California, a health care ethics consulting firm serving hospitals, HMOs and other health care delivery systems. I designed and facilitated the Oregon Medicaid Priority Setting Project and facilitated the Governor's Blue Ribbon Panel in Hawaii on health care delivery. My experience in these states as well as my work in new technology assessment for Kaiser Permanente and Group Health, Cooperative of Puget Sound lead me to the following deliberations.

Fundamental to successful health care reform will be the delineation of a benefits package which is comprehensive without exposing patients to unnecessary risk, and which does not waste limited resources. Ideally, a benefits package stipulates the provision of broad service categories without reference to specific procedures or technologies, and at a minimum covers all those interventions, and only those interventions, that are effective. Effective interventions are those which have proven benefit in terms meaningful to patients, and whose benefit outweigh their harm. While professional standards help define those indications and interventions that are currently in use and are felt to be effective, studies have shown inappropriate use of common procedures at rates ranging up to 32 %, many with serious associated complications. As the number of potential indications for a single intervention may exceed 2000, and as outcome data for most interventions is not extensive, practice guidelines that rely on consensus opinion of experts will be required. While it is recognized that legitimate regional variation in use patterns exist, effectiveness standards must be uniform nationally and sophisticated enough to capture inappropriate use of services. In addition, greater incorporation of patient preferences regarding risk must be included as patients are more risk averse than their providers when confronting different treatment options.

The elimination of inappropriate care through effectiveness standards offers the opportunity of significant one time savings in health care expenditure. However, the aging and growth of the population, and the explosive growth and implementation of new technology suggest that elimination of waste will not be enough to deliver high quality care to all Americans. Benefits package design must be prepared to address the issue of care that is beneficial, but only marginally so, and which may come at great cost. In addition to significant amounts of inappropriate care, studies have shown a significant number of interventions which have limited benefit and a significant number of interventions which are done for unclear reasons. As with inappropriate care, no simple association with provider patterns can be identified. This necessitates the determination of what interventions are "appropriate" (equivalent to "adequate", "basic", and "essential"), that is, what care constitutes an acceptable minimum. Defining appropriate care has three requirements. First, net benefit and total costs of interventions must be known. Second, this information must be known at the interventional level and frequently by indication. Third, and most important, defining appropriate care will involve value judgements.

While many professional groups are content to define "appropriate" only as it applies in a narrow technical/interventional sense, value assessments which involve the public must appropriately apply an overriding community standard in their determination. While individuals cannot be expected to understand the intricacies of the strategies used in medical intervention, it has been shown that citizens can consistently prioritize services using agreed upon principles for health care resource allocation when those services have been previously evaluated in terms of effectiveness by the professional community. This process must, however, make corrections for and acknowledge that the grouping of interventions into categories understandable to the general public will necessarily undervalue many individual patients scenarios where intervention is strongly appropriate.

Page two

Both the Netherlands Committee on Choices in Health Care and those involved in reform initiatives in Oregon have outlined strategies which acknowledge both ineffective and inappropriate care, and the need to make the difficult choices involved in deciding what care represents an adequate minimum. By "creating community" through a public consensus building process, an effective and appropriate benefits package can be developed in light of professional insight, outcome data, and relevant social values.

## STATEMENT

BY THE

CENTER FOR POPULATION OPTIONS

Margaret Pruitt Clark, Ph.D.  
Executive Director

Pamela Haughton-Denniston  
Director of Public Affairs

The Center for Population Options (CPO) is the only national, non-profit organization dedicated to increasing the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, CPO has provided information, education and advocacy to youth-serving agencies and professionals, policymakers and the media in the areas of teen pregnancy, HIV/AIDS and sexually transmitted disease prevention, life-planning and comprehensive sexuality education, and school-based health services for adolescents. In addition, CPO's International Center for Adolescent Fertility has provided training, technical assistance, and materials for adolescent programs in the developing world.

CPO applauds the Subcommittee for holding hearings to solicit views from the public and from interest groups on the package of benefits that should be offered through any national health care program. Much of the publicity on health reform has focused on the difficulty in reconciling apparently conflicting goals: universal access and cost containment. To date there has been little media attention on the specific services that would be incorporated into the basic package, except to note that there will necessarily be limits.

CPO is deeply concerned that the Administration and the Congress be aware of the unique health needs of adolescents, and urges the committee to keep America's 31 million adolescents centrally in mind as it develops basic benefits packages and financing and delivery systems.

According to the Office of Technology Assessment, "(a)dolescents are commonly regarded as among the healthiest of Americans, and those least in need of health services. Perhaps as a consequence, adolescent

health has not been a national priority. Yet...perhaps one out of five of today's 31 million adolescents have at least one serious health problem."

One out of seven (4.6 million) adolescents is uninsured. The barriers to adequate health care for adolescents are not merely financial, however. This population is the least likely of any age group to use the services of private, office-based physicians. For a variety of developmental, psychological and social reasons, adolescents are unlikely to seek early or preventive care, especially if receiving that care requires advance planning and follow-up. Thus, the location and structure of services are critical components in ensuring adolescent access to services.

Many health problems associated with adolescence -- teen pregnancy, the sexual transmission of diseases (including HIV), drug and alcohol abuse, and injury from violence -- are related to risk-taking behaviors. In addition, many health problems of later life are directly attributable to behavior patterns established in adolescence or earlier, such as eating patterns and smoking.

Preventing these health problems requires strategies more complex than simply immunizations or screenings. Unless prevention strategies incorporate comprehensive health education, teach skills and provide concrete aid -- such as contraceptives and condoms -- they will not succeed in effecting behavior change or reducing the burden on the health care system. These burdens are enormous. For instance, CPO estimates that in 1990 the federal government spent \$18.57 billion in Medicaid payments for families begun with a teen birth.



The attached Principles for National Health Care Reform were developed by CPO's board of directors to help encourage plans that are responsive to the needs of adolescents. Health education and counseling, mental health services, and confidential access to comprehensive reproductive health care are indispensable components in any plan to promote adolescent health.

In addition, the following "Consensus Statement on Adolescents and Health Care Reform" has been endorsed by a number of national organizations, including the Society for Adolescent Medicine, Camp Fire Boys and Girls, and the United States Student Association:

Adequately providing for the health needs of young people up to the age of 24 presents a special challenge for health care reform because of the developmental, behavioral and psychosocial aspects of adolescence. At the same time, providing appropriate care for this population presents a unique opportunity for prevention and future cost savings through early diagnosis and treatment of chronic and other conditions, and through modification of health related behaviors, including sexual behaviors that lead to pregnancy, sexually transmitted diseases, and AIDS. The following groups agree that health care reform must adequately address adolescents' needs, and provide for the delivery of preventive and reproductive health services to adolescents.

CPO urges the Subcommittee to evaluate the Administration or other proposals according to these principles, and ensure that the health needs of adolescents are adequately met.

**The Center for Population Options**  
**Principles for National Health Care Reform**  
**March 1993**

Adequately providing for the health needs of young people, up to the age of 24, presents a special challenge for health care reform because of the developmental, behavioral, and psychosocial aspects of adolescence. At the same time, providing appropriate care for this population presents a unique opportunity for prevention and future cost savings through early diagnosis and treatment of chronic and other conditions, and through modification of health related behaviors, including sexual behaviors that lead to pregnancy, sexually transmitted diseases, and AIDS. In order to meet the health needs of adolescents and to realize cost savings through prevention, the Center for Population Options believes that the following elements are critical components of any national health care reform effort.

- Comprehensive primary and preventive care that is responsive to their special needs based on age and developmental status must be available to all adolescents.
- The package of benefits must include, in addition to basic preventive and acute care services: contraceptive services and supplies, drugs and devices; abortion services; screening for and treatment of sexually transmitted disease including HIV infection; inpatient and outpatient substance abuse counseling and treatment; and inpatient and outpatient mental health counseling and treatment.
- Services must be available in a wide range of health care settings, including family planning and other community-based public health clinics, school-based and school-linked health clinics, physicians' offices, HMOs, and hospitals. Strong preference should be given to maintaining current entry points for health care service that are well known to and frequently used by adolescents.
- Individual adolescents must have access to a provider of their choice who has training and experience in adolescent health issues and who is sensitive to the special needs of the adolescent population.
- Adolescents must be provided with a full range of services. If individual providers choose not to provide particular services, they should be required to provide referrals to others who do.

- \* Adolescents must be assured strict confidentiality by all providers and be allowed to give their own consent for services when third-party consent requirements would be a barrier.
- \* Adolescents should not be denied necessary health care, including preventive drugs or devices, based on their ability to pay or insurance status.
- \* Reimbursement or other financial support must be available for services provided by health and mental health care professionals other than physicians, including nurse practitioners, nurse midwives, and other mid-level health and mental health care professionals.
- \* Any comprehensive system of health care financing and service delivery should include community and school-based health education services.

In addition, the Center for Population Options endorses the criteria for national health care reform spelled out by the Society for Adolescent Medicine<sup>1</sup>:

1. **Availability:** Age-appropriate services and trained health-care providers must be present in all communities.
2. **Visibility:** Health services for adolescents must be recognizable, convenient, and should not require extensive or complex planning by adolescents or their parents.
3. **Quality:** A basic level of services must be provided to all youth, and adolescents should be satisfied with the care they receive.
4. **Confidentiality:** Adolescents should be encouraged to involve their families in health decisions, but confidentiality must be assured.
5. **Affordability:** Public and private insurance programs must provide adolescents with both preventive and other services designed to promote health behaviors and decrease morbidity and mortality.
6. **Flexibility:** Services, providers, and delivery sites must consider the cultural, ethnic, and social diversity among adolescents.
7. **Coordination:** Service providers must ensure that comprehensive services are available to adolescents.

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<sup>1</sup> Society for Adolescent Medicine, "Access to Health Care for Adolescents: A Position Paper," *Journal of Adolescent Health* 13 (1992): 162-170.

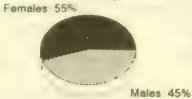
## The Facts



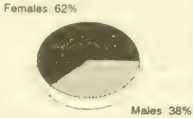
## SCHOOL-BASED AND SCHOOL-LINKED CLINICS

### Clinic Enrollment

#### Gender Composition

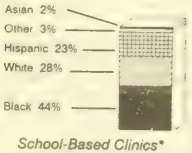


School-Based Clinics\*

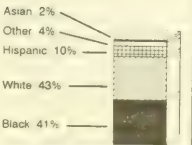


School-Linked Clinics

#### Ethnic/Racial Composition



School-Based Clinics\*



School-Linked Clinics

\* Gender and ethnic/racial composition of School-Based Clinic enrollment approximates that of school population

School-based clinics (SBCs) and school-linked clinics (SLCs) are comprehensive health care centers that provide a wide range of health and social services to adolescents at or near where they spend much of their day -- school. They are designed to overcome barriers to adolescent health care use including concerns over confidentiality, lack of transportation, inconvenient appointment times, cost, lack of insurance coverage and general apprehension or disinterest among adolescents about discussing personal health problems. SLCs differ from the conventional model of SBCs in that they often are free-standing adolescent health clinics which serve youth from more than one school and youth who are not in school. Each clinic is unique, with programs responsive to local needs.

### 327 Clinics Served Senior High, Junior High and Elementary School Students in the 1989-90 School Year<sup>1</sup>

- The number of school-based clinics identified by the Center for Population Options increased significantly from 31 in 1984, to 150 in 1989. By early 1991, 306 school-based and 21 school-linked clinics operating in 33 states and Puerto Rico had been identified.
- SBCs typically serve only one school. Of those identified, 51 percent operate in high schools, 13 percent operate in junior high and middle schools and 19 percent operate in elementary schools. 12 percent operate in schools with combined grade levels.
- SLCs typically serve students from more than one school and more than one grade level. The average number of schools served is 6.5 with an average total enrollment of 5,017. Most SLCs also serve out-of-school youth.

### Most SBCs and SLCs Offer a Wide Range of Medical and Non-Medical Services, But Few Provide Contraceptives

- The medical services provided by SBCs and SLCs are generally similar. Over 90 percent of clinics offer assessment and referrals to community health care providers and private local physicians; general primary health care; diagnosis and treatment of minor injuries; and routine or sports physicals.
- Over two-thirds of the clinics perform routine lab tests, including pregnancy tests, prescribe and dispense medication, manage chronic illnesses, give immunizations and make referrals for prenatal care. More than half diagnose and treat sexually transmitted diseases (STDs) and perform gynecological examinations.
- A majority of both SBCs and SLCs provide education and counseling services, including drug and substance abuse programs, sex education, family and mental health counseling, nutrition education, health education, AIDS education and counseling, weight reduction services and parenting education.
- Over 60 percent of SBCs provide counseling, referral or follow-up for family planning methods during the school year, but only 28 percent write prescriptions for birth control pills and fewer than 20 percent dispense any kind of contraceptives on-site.
- SLCs are somewhat more likely to provide family planning services than SBCs. Nearly half of SLCs write prescriptions for contraceptives or dispense birth control pills, and slightly less than half make condoms and foam available in the clinic.

### Over Half of All Clinic Users Have No Other Source of Health Care

- Approximately half of all students and three-fifths of elementary and junior high/middle school students using school-based and school-linked clinics do not have access to other sources of health care. In some clinics, the proportion of teens without access to other health care approaches 100 percent.
- Less than 20 percent of clinic users are covered by private insurance or health maintenance organizations; nearly 40 percent are completely uninsured.
- Overall an average of 714 students were enrolled in each SBC during the 1989-90 school year - about half the average school enrollment. SLCs, with a much larger target audience, enrolled an average of 1,133 students during the 1989-90 year.



## References

- <sup>1</sup>Except where otherwise noted, information in this fact sheet comes from: C. Wazsak and S. Neidell, *School-Based and School-Linked Clinics: Update 1991*, Center for Population Options (CPO): Washington, DC, 1991.
- <sup>2</sup>L.S. Zabin, et al., "Evaluation of a Pregnancy Prevention Program for Urban Teenagers," *Family Planning Perspectives*, May/June 1986.
- <sup>3</sup>D. Kirby, C. Wazsak, J. Ziegler, "Six School-Based Clinics: Their Reproductive Health Services and Impact on Sexual Behavior," *Family Planning Perspectives*, Jan/Feb 1991.
- <sup>4</sup>D. Kirby and C.S. Wazsak, *An Assessment of Six School-Based Clinics: Services, Impact and Potential*, CPO: Washington, DC, 1989.
- <sup>5</sup>C.D. Hayes, ed., *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, Vol. 1, National Research Council of the National Academy of Sciences, National Academy Press, Washington, DC, 1987; American Academy of Pediatrics, *AAP News*, Apr 1987; *Code Blue: Uniting for Healthier Youth*, The National Commission on the Role of the School and the Community in Improving Adolescent Health, National Association of State Boards of Education and American Medical Association, 1990; National PTA, *Legislative Directive*, Update Sep 1991; *Adolescent Health, Volume 1: Summary and Policy Options*, Congress of the United States, Office of Technology Assessment, Apr 1991.
- <sup>6</sup>Random sampling by telephone of Portland school district residents, unpublished data by Decision Sciences, Inc.: Portland, OR, 1986.
- <sup>7</sup>Project Outreach, *Opinions of Michigan Citizens About the Public Schools*, Fifth Annual Statewide Michigan Education Survey, Michigan State Board of Education: Lansing, MI, 1986.
- <sup>8</sup>The Roper Organization Inc., *AIDS: Public Attitudes and Education Needs*, prepared for Gay Men's Health Crisis, New York, NY, 1991.
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- The number of visits to an SBC during the school year ranged from 80 to 8,800, with an average of 1,847 visits per clinic. The average number of visits to each SLC during the school year was 2,483.

### Public Funds Are the Primary Revenue Source for Clinics

- On average, more than half of the funding for the SBCs and SLCs surveyed is provided by state and federal sources, predominantly from state health departments and Maternal and Child Health block grants. City and county governments and school districts may also contribute a portion of operating costs.
- SLCs receive a greater proportion of their budgets than SBCs from state sources -- an average of 53 percent for the 1989-90 school year compared with 28 percent for SBCs. In the same year, federal programs provided only an average of 17 percent of SLC funding, compared with 28 percent for SBCs.
- In 1989-90, only 2 percent of funding for SBCs and 4 percent for SLCs were provided through Medicaid reimbursements.
- Financial support for SBCs from private foundations has decreased from an average of 41 percent of the budget in the 1987-88 school year, to 31 percent in 1988-89, down to 19 percent in 1989-90. SLCs typically receive less than 3 percent of their funds from private foundations.
- Only one-fifth of SBCs and fewer than half of SLCs charge fees for services. Service-related fees typically contribute less than 2 percent of the total operating budgets.

### Health Agencies Are Major Clinic Sponsors

- SBCs and SLCs are administered primarily through health organizations. Three-fourths of SBCs and three-fifths of SLCs surveyed are sponsored by community health clinics, public health departments, hospitals or medical schools.
- Community-based organizations and private, non-profit agencies play a larger role in SLCs, sponsoring 26 percent of SLCs compared with only 6 percent of SBCs. Only 7 percent of either SBCs or SLCs are administered by the school district itself.
- Two-thirds of clinics have advisory boards, which typically include parents, school staff, students and other youth-serving agency and community representatives.

### SBCs and SLCs Can Help Adolescents Delay First Intercourse and Increase Effective Contraceptive Use

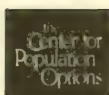
- In Baltimore, at a program providing counseling on two school campuses with medical care nearby, girls enrolled in the program postponed first sexual intercourse seven months longer than girls who were not enrolled.<sup>2</sup>
- One study of six clinics found that there were no greater levels or increased frequency of sexual activity in schools with clinics that made contraceptives available to students.<sup>3</sup>
- According to this same study, in two of the six schools, greater percentages of sexually active students used effective contraception at last intercourse than students in non-clinic schools.<sup>3</sup>
- Students are more likely to seek contraceptive counseling and referrals from SBCs that dispense or prescribe contraceptives than they are from clinics that do not.<sup>4</sup>

### Clinics and Comprehensive Services Receive Strong Public Support

- The National Research Council of the National Academy of Sciences, the American Academy of Pediatrics, the American Medical Association, the National PTA and the congressional Office of Technology Assessment have all issued reports or statements affirming the unique potential of SBCs and SLCs to address the unmet health care needs of adolescents.<sup>5</sup>
- In a Portland, Oregon telephone survey, 77 percent of school district residents who had heard about a school-based clinic opening in their community were in favor of the clinic.<sup>6</sup>
- In a Michigan-wide survey, 80 percent of adults voiced strong support for the availability of confidential services in school-based clinics.<sup>7</sup>
- A 1991 Roper poll found that 64 percent of Americans endorse condom distribution in senior high schools to help control STDs.<sup>8</sup>
- A 1988 Harris poll found that 73 percent of Americans favor making birth control information and contraceptives available through school-based clinics.<sup>9</sup>

Compiled by Janet Riessman, October 1991

## The Facts



## ADOLESCENT SEXUALITY, PREGNANCY AND PARENTHOOD

The United States bears the unfortunate distinction of having the highest adolescent pregnancy, abortion and birth rates in the developed world. According to recent estimates, 43 percent of all adolescent girls will experience at least one pregnancy before they reach age twenty.<sup>1</sup> Too-early childbearing exposes an adolescent and her baby to health risks, truncated education, and poverty. Teenage childbearing is also expensive. In 1988 alone, U.S. taxpayers spent almost \$20 billion to support families started when the mother was a teenager.

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- <sup>2</sup>M. Zelnik and F. Shah, "First Intercourse Among Young Americans," *Family Planning Perspectives (FPP)*, Mar/Apr 1983.
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- <sup>7</sup>NCHS, NSFG, 1982 and 1988.
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- <sup>11</sup>Louis Harris & Associates, *American Teens Speak: Sex, Myths, TV and Birth Control*, a poll conducted for the Planned Parenthood Federation of America, 1986.
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- <sup>13</sup>The Alan Guttmacher Institute (AGI), *Teenage Pregnancy in the United States: The Scope of the Problem and State Responses*, New York, 1989.
- <sup>14</sup>NCHS, "Advance Report of Final Natality Statistics, 1987," *Monthly Vital Statistics Report*, Supplement, June 1989.

### Teens Do Have Sex, Don't Use Contraceptives

- The average age of first sexual intercourse is 16.2 for girls and 15.7 for boys.<sup>2</sup> One study found that among inner-city black males the average age of first intercourse is 11.8.<sup>3</sup>
- Approximately one-fourth of 15-year-old girls and one-third of 15-year-old boys have had sexual intercourse.<sup>4,5</sup> Among all adolescents, 77 percent of females and 86 percent of males are sexually active by age 20.<sup>5,6</sup>
- From 1982 to 1988, the percentage of 15- to 19-year-old girls who had ever had premarital sexual intercourse increased from 43 percent to 51 percent.<sup>7</sup>
- On average, girls who are sexually active wait 11.5 months between initiating intercourse and making their first visit to a family planning clinic. 36 percent visit the clinic only because they suspect they are pregnant.<sup>8</sup>
- More than one-fifth of all initial premarital pregnancies occur in the first month after the initiation of sexual intercourse and half occur within the first six months.<sup>9</sup>
- 41 percent of the 15- to 19-year-old girls surveyed in a recent study reported not using contraception at first intercourse, while 29 percent failed to use contraception at last intercourse.<sup>4</sup>
- 75 percent of all unintended teenage pregnancies occur to adolescents who do not use contraception.<sup>10</sup>
- While latex condoms used consistently and correctly are not 100 percent effective in protecting against sexually transmitted diseases (including the human immunodeficiency virus (HIV), which causes AIDS), they provide the best protection available for people engaging in sexual intercourse. According to one survey, only about one-third of sexually active teenagers report using condoms more often than any other method of contraception.<sup>11</sup>

### There Are More Than One Million Adolescent Pregnancies Each Year

- More than one million teenage girls become pregnant in the United States each year. That's one out of every ten girls under the age of 20.<sup>12</sup>
- Among all teens ages 15 to 19, the pregnancy rate per thousand girls was 110 in 1985, up from 95 per thousand in 1972.<sup>13</sup> The pregnancy rate among sexually active teens, however, has fallen from 264 per thousand in 1970 to 233 per thousand in 1984, probably due to increased contraceptive use.<sup>1</sup>

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- <sup>16</sup>NCHS "Induced Terminations of Pregnancy: Reporting States, 1987," *Monthly Vital Statistics Report*, January 1990.
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- <sup>23</sup>CDF, *Adolescent Pregnancy: An Anatomy of a Social Problem in Search of Comprehensive Solutions*, Washington, D.C., 1987.
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- There were 472,623 births to teenagers in 1987. Two percent of these were to teens ages 14 and younger, 37 percent were to 15- to 17-year-olds, and 61 percent were to 18- to 19-year-olds.<sup>14</sup>
  - Approximately 13 percent of all teenage pregnancies end in miscarriages or stillbirths.<sup>15</sup>
  - 42 percent of pregnancies to both white and non-white 15- to 19-year-olds end in abortion, as do 46 percent of pregnancies to teens 14 and younger.<sup>12</sup> Teenagers account for about one-quarter of the total number of abortions performed in the U.S.<sup>16</sup>
  - Only 4 percent of unmarried teen mothers put their babies up for adoption.<sup>17</sup>
  - 30 percent of teenagers who first give birth at age 16 or younger have a second child within 2 years, compared with 14 percent of women who wait at least until age 22 to have their first child.<sup>18</sup>
  - 18 percent of teenagers who gave birth in 1987 gave birth to their second child; 3 percent gave birth to their third.<sup>14</sup>
  - Other developed countries have lower teen pregnancy, birth and abortion rates than the U.S. In 1981, the U.S. pregnancy rate was 96 per thousand girls ages 15 to 19. The comparable rates were 45 in England and Wales, 43 in France, 44 in Canada, 35 in Sweden, and 14 in the Netherlands. In the United States, the teenage abortion rate alone is as high as, or higher than, the teenage pregnancy rate in any of these countries.<sup>19</sup>

## Pregnant and Parenting Teens Face Health Risks, Academic Failure, and Poverty

- During pregnancy, teenagers are at a much higher risk of suffering from serious medical complications, including anemia, pregnancy-induced hypertension (toxemia), cervical trauma, and premature delivery, than older women.<sup>20</sup>
- The maternal mortality rate for mothers under age 15 is 60 percent greater than for women in their 20's.<sup>20</sup>
- Although prenatal care would help teens to have pregnancy outcomes comparable to those of women in their 20's, teens delay seeking prenatal care, if they seek it at all.<sup>21</sup> 46 percent of teenage mothers do not receive prenatal care during their first trimester, 9 percent do not receive care until their third trimester, and 4 percent do not receive prenatal care at all.<sup>14</sup>
- Infants whose mothers received no prenatal care are 40 times more likely to die during the neonatal stage than infants born to women who received adequate prenatal care.<sup>22</sup>
- Teenage girls who give birth are less likely to ever complete a high school education than their non-parenting peers. At least 40,000 teenage girls drop out of school each year because of pregnancy.<sup>23</sup>
- Only 39 percent of teen fathers receive high school certification by age 20, compared with 86 percent of males who postpone parenting.<sup>24</sup>
- 64 percent of births to teenagers in 1987 were to unmarried teens.<sup>14</sup> Among all women, only 18 percent of unmarried mothers have court orders to receive child support from their children's fathers compared with 74 percent of mothers who have been married.<sup>25</sup>
- At least 60 percent of teenage marriages end in divorce within the first five years.<sup>26</sup>
- Teenage mothers earn about half the lifetime income of women who first give birth in their 20's.<sup>23</sup>
- 70 percent of families maintained by women under age 25 were living below the poverty level in 1987.<sup>27</sup>
- In 1988 alone, the U.S. spent \$19.83 billion on Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp payments to families started when the mother was a teenager.<sup>28</sup> Over half of AFDC payments go to support families begun when the mother was a teenager.<sup>29</sup>

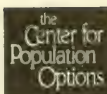
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## The Facts



## Adolescent Substance Use and Sexual Risk-taking Behavior

### Substance Use and STDs

- Crack cocaine has been associated with an increase in the incidence of sexually transmitted diseases.<sup>11</sup> In San Francisco, there was a 35% increase in cases of gonorrhea among 15- to 19-year-olds between 1987 and 1988; the proportion of cases was greatest in neighborhoods with the greatest number of crack-related arrests.<sup>9</sup>
- In a study of sexually active adolescent males admitted to a substance abuse treatment program, 53% were found to have one or more sexually transmitted diseases.<sup>12</sup>
- The exchange of sex for drugs, particularly crack, plays a major role in the spread of sexually transmitted diseases.<sup>11</sup> A study of adolescent crack users found that one in four reported having been involved in an exchange of sex for drugs and/or money.<sup>9</sup>

The use of alcohol, drugs and cigarettes by adolescents poses significant threats to their health. Yet the connection between substance use and other risk-taking behaviors is not often examined. Some research has found that there is a linkage between the use of cigarettes, alcohol and other drugs and sexual activity. Moreover, substance use may impair adolescents' ability to make judgments about sex and contraception, placing them at increased risk of experiencing pregnancy or becoming infected with a sexually transmitted disease, including HIV.

### Increase in Adolescent Sexual Activity Paralleled Increase in Drug Experimentation

- Both experimentation with illicit drugs and sexual activity rose among adolescents over the last two decades. The increased rates of adolescent substance use and sexual activity may be linked either because similar factors influence both, or because engaging in one behavior increases the likelihood of engaging in the other.<sup>1</sup>
- Unlike the rate of sexual activity among adolescents, which continues to increase, illicit drug use among adolescents is declining. However, more than 4.5 million adolescents ages 12 to 17—or one out of five—have tried an illicit drug.<sup>2</sup>
- Adolescents who have lower expectations for academic achievement and who are more influenced by their peers than their parents are more likely than others to engage in risk-taking behaviors such as sexual activity, cigarette smoking and the use of alcohol and other drugs.<sup>1,3,4</sup>
- Adolescents who use marijuana are about three times more likely to be sexually active before age 16 than those with no drug history. The younger the age at first use of drugs, the greater the likelihood of early sexual activity.<sup>1</sup> Among white females under the age of 16, those who smoke cigarettes are four times as likely to engage in sexual activity as those who do not.<sup>3,4</sup>
- Females who initiate intercourse before age 17 are almost twice as likely as their peers who are not sexually experienced to begin using alcohol or marijuana within a year of first intercourse.<sup>5</sup>

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### Substance Use Impairs Judgment and Increases Risk-taking Behaviors

- Among adolescents, sexual activity is often unplanned and often occurs after drinking or drug use.<sup>6,7</sup> One study of adolescents with unintended pregnancies found that almost one-half had been drinking and/or using drugs before the act of intercourse that resulted in the pregnancy.<sup>8</sup>
- The use of alcohol and drugs has been shown to inhibit the ability to practice safer sex or to use contraception at all.<sup>8,9</sup> One study found that among sexually active adolescents who drink and/or use drugs, 16% used condoms less often after drinking and 25% after drug use.<sup>7</sup>
- A survey of college students found that 75% of the males and at least 55% of the females involved in acquaintance rapes had been drinking or using drugs just prior to the attack.<sup>10</sup>
- The use of crack cocaine is associated with high levels of sexual activity and risk-taking. A study of female crack users found that they reported twice as many sexual partners per month as non-users. One-third of black adolescent male crack users in another study reported ten or more sexual partners in the last year.<sup>9</sup>



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<sup>18</sup>1990 National Senior High School Survey," NIDA: Rockville, MD, 1991. This survey includes only in-school youth; dropouts, youth who are chronically absent, and those in juvenile detention centers are not represented. Levels of drug use are greater than average in these high-risk populations.

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## Rates of Sexual Activity and Substance Use Differ According to Race and Gender

- Several studies have shown that rates of alcohol, cigarette and marijuana use are higher among white adolescents than among black or Hispanic adolescents.<sup>9,10</sup> Black adolescents are more likely to be sexually active than their white or Hispanic peers.<sup>1,13</sup>
- Black adolescents report lower rates of alcohol and drug use than their white peers. Hispanic teens report more substance use than black teens, but only slightly less than white teens. Native American adolescents report the highest rates of alcohol and drug use; Asian-American teens report the lowest.<sup>14</sup>
- 89% of high school seniors report having tried alcohol.<sup>15</sup> White and Native American males report the highest rates of heavy drinking: almost half report having 5 or more drinks in a row in the last two weeks. One-third of the females of these groups report heavy drinking. Among black and Asian-American females, only one in ten reports heavy drinking.<sup>14</sup>
- 19% of high school seniors report daily use of cigarettes. Two-thirds of all adolescents have tried cigarettes; 29% report smoking within the last month. Females tend to smoke at slightly higher rates than males.<sup>15</sup>
- Four out of ten high school seniors report having tried marijuana. White males and Native American males and females report the highest rates of current marijuana use: one-fourth report using marijuana in the last month. Fewer than 10% of black, Puerto Rican, and Latin American females and Asian American males and females report marijuana use in the last month.<sup>14</sup>
- 9% of high school seniors report having ever tried cocaine, and about 4% report having tried crack.<sup>15</sup> Rates of cocaine use are lowest among black and Asian-American adolescents. Hispanic males and Native American males and females report the highest rates of cocaine use: between 7 and 9% of high school seniors in these groups report using cocaine in the last month. Among white high school seniors, 4% of females and 6% of males report using cocaine in the last month.<sup>14</sup>
- Males are more likely than females at any age to use marijuana or alcohol or to be sexually active. Among females at any age, white adolescents are more likely than black or Hispanic adolescents to have begun using alcohol or marijuana.<sup>9</sup>

## Most Adolescents Perceive Risks, but Peer Pressure Plays a Role in Alcohol and Drug Use

- While only 23% of high school seniors believe it is harmful to try marijuana once or twice, 78% believe it is harmful to smoke marijuana regularly. 60% believe that trying cocaine once or twice is harmful. Nine out of ten believe regular use of cocaine is harmful.<sup>19</sup>
- Black adolescents are more likely than whites to perceive that drug use involves high risks, and to disapprove of drug use.<sup>14</sup>
- Adolescents perceive less harm in the use of alcohol than in the use of drugs. Only one-third of high school seniors believe it is harmful to take one or two drinks every day; almost half believe that it is not harmful to have five or more drinks once or twice a weekend.<sup>15</sup>
- 21% of high school students report feeling "a lot" of pressure to drink alcohol. 7% report feeling "a lot" of pressure to use drugs. Adolescents from socio-economically disadvantaged backgrounds are three times more likely than others to report feeling pressured to use drugs.<sup>16</sup>
- According to one survey, adolescents rate the mass media as their best source of information about alcohol and drugs. However, black adolescents report seeking information about alcohol and drugs from their families more often than do white adolescents. Moreover, white adolescents are twice as likely to believe what their friends tell them about alcohol and drugs as are black adolescents.<sup>17</sup>

Compiled by Elizabeth Armstrong, July 1991

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# The Facts

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## ADOLESCENTS, HIV AND OTHER SEXUALLY TRANSMITTED DISEASES (STDs)

Although the number of reported adolescent AIDS cases is relatively low, the vast majority of youth with HIV are not included in the country's AIDS statistics, given a median 8-10 year incubation between infection and diagnosis. Furthermore, one out of five people with AIDS aged 20-29 probably was infected as a teen. Teens also have the highest rates of STDs of any age group, causing severe health consequences and further indicating risk for HIV. To curb the AIDS epidemic, studies prove that adolescents need long-term, comprehensive and skills-based interventions.<sup>1</sup>

### HIV is Spreading Rapidly Among Teens

- The Centers for Disease Control and Prevention (CDC) estimates that approximately one million Americans are infected with HIV and that at least 40,000 new HIV infections occur each year among adolescents and adults.<sup>2</sup> AIDS is the sixth leading cause of death for 15-24 year-olds.<sup>3</sup>
- 946 cases of AIDS among teenagers ages 13-19 were reported to the CDC by the end of 1992. When cases among 20-24 year-olds are added, the total increases to 10,528.<sup>4</sup> Between December 1990 and December 1992, the number of AIDS cases among 13-24 year-olds increased by 43 percent.<sup>5,6</sup>
- National studies indicate varying infection rates for teens. Among teenagers who applied for military service between 1985 and 1989, one out of 3,000 tested positive for HIV; for African American teens, the infection rate was one in 1,000.<sup>6</sup> Among U.S. Job Corps entrants between 1987 and 1990, more than one in 300 youth ages 16-21 tested HIV positive. Among African American and Hispanic entrants at age 21, the infection rate was nearly one in 80.<sup>7</sup> Both studies found higher infection rates among women than men ages 16-18.
- Between November 30, 1987 and March 31, 1990, one in 170 women under age 20 who gave birth in New York City was infected with HIV.<sup>8</sup> Over a four-month period in 1987, about one in 50 teens at an STD clinic in Baltimore was infected with HIV.<sup>9</sup> Between 1987 and 1992, the rate of HIV infection among youth ages 13-21 receiving ambulatory care in Washington D.C. increased from one in 248 to one in 57.<sup>10</sup>
- A greater percentage of adolescents than adults with AIDS are female (29 percent vs. 11 percent), are African American and Hispanic (58 percent vs. 46 percent) and were infected with HIV through heterosexual contact (16 percent vs. 6 percent). Among teenage women with AIDS, 72 percent are African American or Hispanic.<sup>4</sup>
- Young gay males face particularly high risks for HIV. In a study of 29 gay or bisexual male adolescents ages 15-19, almost half reported having had a STD.<sup>11</sup>
- AIDS cases among people under age 25 have been reported in 49 states, the District of Columbia and nearly 100 large cities. Almost one-third of the teen AIDS cases are in communities with populations of less than 500,000.<sup>12</sup>

### High Rates of STDs Pose Major Health Threat

- Every year, three million teens—one out of every six—are infected with an STD. In 1990, almost two-thirds of the reported 12 million STD cases were among people under age 25.<sup>13</sup>
- Lesions from STDs, such as syphilis and genital herpes, facilitate transmission of HIV.<sup>14</sup>
- In one study, 38 percent of sexually active teens had the human papillomavirus (HPV) which causes genital warts and is associated with a higher risk of cervical cancer.<sup>15</sup>
- Many STD infections are asymptomatic or display symptoms that adolescents do not recognize. Left untreated, STDs can result in death, pelvic inflammatory disease, ectopic pregnancy, infertility, neoplasia, adverse pregnancy outcome, infant pneumonia, infant death, mental retardation and immune deficiencies.<sup>13</sup>

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- Risk of pelvic inflammatory disease (PID), associated with chronic pelvic pain, infertility and increased risk of ectopic pregnancy, is estimated at one in eight for sexually active 15-year-olds, compared to one in 80 for sexually active women age 24 and older.<sup>16</sup>
- Condom Use Increasing But Many Youth Still Have Unprotected Intercourse, Often with Multiple Partners**
  - Sexual activity among adolescent women ages 15-19 increased from 47 percent in 1982 to 53 percent in 1988—with the greatest increases occurring among white and non-poor teenagers.<sup>17</sup> Among urban males, ages 17-19, 76 percent reported having had sexual intercourse in 1988—up from 66 percent in 1979.<sup>18</sup>
  - In 1988, 26 percent of both white females and males, 33 percent of Hispanic males and 69 percent of African American males reported having sexual intercourse by age 15.<sup>19,18</sup>
  - Although little data exist on anal intercourse among adolescents, a study found that over one-fourth of teenage females attending an adolescent clinic in New York City reported having had anal intercourse.<sup>21</sup>
  - In 1990, one in four 12th graders reported four or more sexual partners. Only 41 percent of students with multiple sex partners in 1990 reported using condoms at last sexual intercourse and only 45 percent of all sexually active students reported doing so.<sup>20</sup>
  - Between 1982 and 1988, the proportion of sexually active 15 to 19-year old females who reported using condoms at first intercourse more than doubled—from 23 percent to 47 percent.<sup>17</sup> Among sexually active urban males, aged 17-19, reported condom use at last intercourse increased from 21 percent in 1979 to 58 percent in 1988.<sup>18</sup>
- High-Risk Situations and Abuse Make Youth Vulnerable**
  - The use of crack cocaine is associated with high levels of sexual activity and risk-taking. A study of female crack users found that they reported twice as many sexual partners per month as non-users.<sup>22</sup>
  - Approximately one million youth leave home each year due to family conflict, violence and abuse.<sup>23</sup> In a shelter serving runaway and homeless youth in New York City, almost all (91 percent) reported sexual activity, with an average of three sexual partners per week. Thirty-eight percent said they used crack and 29 percent admitted to exchanging sex for food, money, shelter or drugs.<sup>24</sup>
  - Nationally, approximately one in four girls and one in six boys are sexually assaulted before age 18. A history of sexual abuse has been associated with behaviors that increase risk of exposure to HIV—such as prostitution, teenage pregnancy and multiple sexual partners.<sup>25</sup>
  - One in four gay or bisexual males is forced out of the parental home prematurely due to issues of sexual orientation. Up to half resort to prostitution to support themselves, and dramatically increasing their risk of HIV infection.<sup>26</sup>
- HIV Education in Schools Has Increased But Content Still Lacking**
  - All states either mandate or recommend HIV/AIDS education and two-thirds (34 states) require it through law or policy. A state mandate does not necessarily reflect the quality of programs offered as they may be inadequately funded or lack political support for strong local programming.<sup>27</sup>
  - While all states stress abstinence, only 11 states provide balanced information on safer sex and abstinence. Thirty-seven states indicate that they include condom information for prevention, but only five states provide information on how to use, obtain and dispose of condoms.<sup>28</sup>
  - 94 percent of Americans surveyed support HIV/AIDS education in schools; 80 percent believe it should include information about condoms. Nearly all said instruction about condom use should occur by the time students complete junior high or middle school and 40 percent think it is acceptable to teach about condoms in grade school.<sup>29</sup>
  - Runaway youth in New York City, who participated in up to 30 comprehensive HIV/AIDS intervention sessions, reported significant increases in consistent condom use and decreases in high-risk patterns of sexual behavior. The impact of the program increased with each successive intervention.<sup>30</sup>



# CITIZENS COMMISSION ON HUMAN RIGHTS

*Investigating and Exposing Psychiatric Violations of Human Rights Since 1969  
Established by the Church of Scientology.*



## STATEMENT OF TANYA BIBEAU, EXECUTIVE DIRECTOR, CITIZENS COMMISSION ON HUMAN RIGHTS

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you this morning. My testimony will focus on why mental health coverage should not be included in any mandated standardized health benefits package.

I represent the Citizens Commission on Human Rights (CCHR), an international organization which has been investigating and exposing psychiatric violations of human rights since 1969. I am the Executive Director for all operations of the Commission within the United States.

The following comments regarding the Citizens Commission on Human Rights were published in a November 1986 report by the United Nations:

"The main task of CCHR has been to achieve reform in the field of mental health and the preservation of the rights of individuals under the Universal Declaration of Human Rights.

"CCHR has been responsible for many great reforms. At least 30 bills throughout the world which would otherwise have inhibited even more the rights of mental patients, or would have given psychiatry the power to commit minority groups and individuals against their will, have been defeated by CCHR's actions.

"All over the world, branches of CCHR offered help to members of parliaments to increase their awareness of mental health situations, so that actual reform could occur."

The United Nations report went on to state that "Governments should start immediately to investigate psychiatry and the mental health field and get the real facts..."

Mr. Chairman, today I am here to give you and the other distinguished members of the Subcommittee the real facts.

Our commission is deeply concerned about the affordability and accessibility of health care for Americans. A mandated minimum benefits package to be defined by the federal government and possibly offered to Health Insurance Purchasing Cooperatives (HIPCs) should be not only be cost-effective, but also include only safe and effective treatments.

Based on our research and investigations, certain psychiatric treatments and drugs are not designed to cure people, but rather, are used as a method of controlling the individual. Treatments such as electroshock and psychiatric drugs such as Thorazine (once termed the "chemical lobotomy"), which at one time were used as a method of controlling a very small segment of society who were declared "harmful to themselves or others", have now become the norm of treatment for millions of Americans including children as young as 8 years old.

Since the psychiatric industry regulates and controls itself, it has been left free to develop iatrogenic (doctor-created) disease and disability through its treatments and drugs which has unnecessarily cost Americans billions of dollars.



Hundreds of thousands of people suffer from the permanent neurological damage, called Tardive Dyskinesia and Tardive dystonia, because of psychiatric drugs such as Stelazine, Thorazine, Mellaril and Haldol.

Approximately 100,000 people a year, mostly elderly women, are electro-shocked into a brain damaged condition, some no longer even able to remember their children's names or the neighborhood in which they live.

During the past 25 years there has been a rising epidemic of psychiatrists and psychotherapists sexually abusing their patients. This has led 13 states to pass laws and others to introduce legislation to criminalize this blatant abuse of trust. It has taken the criminal prosecution of several leading psychiatrists and numerous articles in newspapers and magazines, T.V. programs and radio shows about the sexual abuse of patients to move the American Psychiatric Association into even considering revising its Ethics Code to close a loophole which many psychiatrists have used to take sexual advantage of patients.

Nationwide, we are witnessing a substantial increase in acts of senseless violence by people under the influence of dangerous psychiatric drugs. In almost every one of these cases, these individuals were not violent prior to taking these drugs.

Also, as reported in newspapers across the country over the past year, the private, for-profit psychiatric hospital industry has taken on a creative skill in psychiatric diagnoses, raising it to a new height of fraud. In effect, thousands of individuals, mostly adolescents, have been incarcerated for "illnesses" they didn't have and have received "treatment" when they didn't need it. Some of these hospitals even made up diagnoses to take advantage of the insurance benefits available for a particular patient, such as an alcoholic being labelled suicidal, because the benefits were so much better for a suicidal diagnoses.

You may ask, as we have - "Where are the checks upon this industry and does the government know that it's allowing the psychiatric-pharmaceutical industry to run roughshod over the health of Americans and also financing the majority of it?"

Data concerning the cost-effectiveness of mental health comes only from the mental health field, and is less than objective, to say the least. A short review of the funding for mental health reveals that since 1960, Federal, state and county governments have continuously increased it to the staggering 1990 figure of over \$36 Billion dollars, that's over a 2,400% increase in 30 years. A March 16th New York Times article reported that the Federal funding alone, through Medicaid, Medicare and other Federal programs, for mental health amounts to over \$17 Billion dollars.

With hundreds of billions of dollars invested over the past three decades in mental health, one would think that the actual causes for mental illness would have been discovered and non-invasive and non-damaging treatments developed for patients. In actual fact, nothing could be further from the truth. Hundreds of thousands of Americans are currently legal "drug addicts" since they cannot get off of the extremely addictive psychiatric drugs they are on without literally going insane, and as mentioned before, we now have on our hands an epidemic of iatrogenic disease caused by these drugs. Psychiatrists are purposefully inducing brain damage through seizures and convulsions using electroshock and calling it "therapy", when neurologists do everything they can to prevent an epileptic from having seizures, because they know that seizures damage the brain.

The fact of the matter is that there has been a further decline in those areas of society that psychiatric influence has permeated, not only in the medical field but also in the education and the criminal justice systems.

The decline in the quality of American education is coincident with a rapid increase in the number of psychiatrists and psychologists working within the nation's school system in the early 1960s, and the destruction, through "values clarification", of the concept of "right" and "wrong".

Despite psychiatry's claim that it can reduce violence with its practices, the statistics of increasing violent crime and increasing costs to the criminal justice system show that the psychiatric industry is culpable here as well. With increased psychiatric funding and the decline in moral standards in society, the cost of the criminal justice system has soared from \$3.75 Billion in 1980 to over \$15 Billion in 1990.

The fact that psychiatry cannot survive without the majority of its revenue coming from government funds further shows its ineffectiveness. A thorough investigation into the waste of government funds by psychiatry would be very revealing, and we strongly recommend it be done.

I would like to cite one prime example of how the psychiatric industry has betrayed our trust. Starting in the mid-1980s the psychiatric industry attempted to survive "on its own", through private, ~~for-profit~~ psychiatric hospitals. By 1990, insurance executives were complaining that the costs of psychiatric care were skyrocketing compared with other medical costs, with admissions for adolescents alone to psychiatric facilities rising 450% from 1984-1987.

As Representative Pat Schroeder (D-CO), Chairwoman of the House Select Committee on Children, Youth and Families, stated in a congressional hearing on April 28, 1992, the private, for profit psychiatric hospitals were involved in "one of the most disgraceful and scandalous episodes in health care in America that I've seen in a long time."

Her committee found in their nationwide investigation that thousands of adolescents, teenagers and adults had been hospitalized for psychiatric treatment that they didn't need; that hospitals hired "bounty hunters" who "kidnapped" patients with mental health insurance; that patients were kept against their will until their insurance benefits ran out; that psychiatrists were being pressured by the hospitals to alter their diagnoses to increase profits; that psychiatric hospitals "infiltrated" schools by paying kickbacks to school counselors who "delivered" students to their facilities; that bonuses were paid to hospital employees, including psychiatrists, for keeping the hospital beds filled; and that military dependents were being targeted for their generous mental health benefits.

As a direct result of the hearing by the House Select Committee on Children, Youth and Families last year, investigations were begun by the Federal Trade Commission, the FBI, the GAO and the Inspector General's Office of the Department of Health and Human Services.

The facts are that the psychiatric industry, left unfettered by government regulation, has shown it cannot and will not restrain itself from taking the highest insurance benefits it can gain, even if it means making up diagnoses to fit the insurance plan. We submit that the evidence contained herein proves that any proposed standardized minimum health benefits package should exclude coverage for mental health.

It would be far too costly to mandate any coverage of this type in a minimum benefits package, especially for employers. Rather, it should be made optional for an additional fee to be

paid by those who want the coverage, thereby satisfying those who need it without burdening employers with the added cost of providing it for everyone.

Our commission is in favor of the concept of "managed competition" and in particular the establishment of an Outcomes Management Standards Board (OMSB). The OMSB will design and oversee a nationwide quality reporting system, based primarily on outcomes measures, for all accountable health plans. What should be included in this are periodic evaluations of outcomes of psychiatric treatment from other medical specialties, to get an objective viewpoint.

Current studies on electroshock and neuroleptic drugs show that they are not only ineffective but also physically damaging to the patient. It is our opinion that when outcomes data is gathered on these psychiatric "treatments", they will not stand up as valid medical treatments.

CCHR is concerned also that large numbers of so-called "mental patients" are not screened for active physical ailments and diseases before admission to psychiatric facilities. In many cases, the undiagnosed physical problems are the direct cause of the so-called mental disorder.

A California study entitled "Medical Evaluation of Psychiatric Patients", published in the Archives of General Psychiatry, Vol 46, August 1989, estimated that of the more than 300,000 patients treated in the California public mental health system in fiscal year 1983 to 1984, 45% had active, important physical disease. The mental health system had recognized only 47% of the study patients' physical diseases, including 32 of 38 diseases causing a mental disorder and 23 of 51 diseases exacerbating a mental disorder. The study went on to suggest that patients treated in the public sector mental health facilities should receive careful medical evaluations upon admission and before treatment.

The Citizens Commission on Human Rights recommends that mandatory physical examinations by a competent medical doctor, not a psychiatrist or other mental health care provider, be implemented for anyone who is scheduled to enter a psychiatric facility. This would include but not be limited to complete blood work-ups, testing for all types of allergies including food allergies and environmental toxins. Treatments should also be given for the physical ailments found by competent physicians before the patient is admitted to a psychiatric facility.

Mr. Chairman, I have provided an entire copy of our Health Care Reform Proposal for the record which covers other aspects of reform not only in the mental health field but also with the Food and Drug Administration which we feel should be implemented not only to bring the spiraling cost of health care under control but also to save lives.

CCHR strongly supports the efforts to reform a health care system and appreciates the difficult decisions facing the Administration, the Congress, the health care providers, the insurance industry, employers and consumers. It is therefore imperative, in our judgement, that any mandated coverage be limited in both coverage and cost to only the most essential and major medical concerns. CCHR looks forward to working with you and the Subcommittee in crafting a realistic, cost-effective health care reform package.

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## HEALTH CARE REFORM

The Citizens Commission on Human Rights (CCHR) is an international organization which has been investigating and exposing psychiatric violations of human rights since 1969. CCHR is concerned about the affordability and accessibility of health care for Americans, and offers the following recommendations to assist policy makers in their decisions to reform the existing health care system.

There is no question that a new plan for health care in America which will afford every American the opportunity to have health care coverage will be debated and enacted into law within the next two years.

The universal coverage idea is centered around the fact that a standardized package of benefits would be made available, the contents to be set by a national board, which would define which medical procedures to be covered as well as the financial parameters, such as co-payments, deductibles and annual caps on out-of-pocket costs.

## STANDARDIZED BENEFITS VS. TREATMENT OUTCOMES

If a standardized minimum benefits package is to be defined by the federal government and offered to Health Insurance Purchasing Cooperatives (HIPCs), it should not only be cost-effective for employers, but also should only include safe and effective treatments.

One of the psychiatric treatments the federal government has been funding through Medicaid and which has dubious results, is electro-convulsive or electro-shock therapy (ECT). Many scientific studies and published papers suggest that ECT causes irreversible brain damage and permanent memory loss.

A recent review of thirteen published studies of controlled "real" versus "sham" (or false) ECT found that not only were each flawed, but also concluded that real ECT is no more effective in treating depression than no treatment at all. CCHR recommends that all current federal government funding of the practice of ECT be stopped. Further, ECT should not be made part of the standardized benefits package of any health care reform measure passed by Congress.

CCHR also recommends that GAO study the "treatment outcomes" on patients that have been electro-shocked, with particular emphasis on the cost to the federal government of patients who became disabled or unable to work after being electro-shocked.

## CUTTING FRAUD, WASTE AND ABUSE

Although the United States has one of the most technologically advanced health care systems in the world, it has been an invitation for some to invent schemes to rip-off the system, resulting in higher insurance costs for all.

These schemes have been highlighted in recent congressional hearings by the House Select Committee on Children, Youth and Families, the House Judiciary Committee's Subcommittee on Crime and Criminal Justice, and the House Ways and Means Committee's Health Subcommittee.

Also, investigations into insurance fraud and patient abuse are currently being conducted by the FBI, FTC and the Inspector General's Office of the Department of Health and Human Services.

We strongly recommend that Congress pass legislation, such as HR 200, introduced by Congressman Stark (D-CA) and Levin (D-MI), to deal with this \$80 billion per year problem.



# MENTAL HEALTH REFORM

Since the 1960s, the funding of psychiatry and psychiatric institutions by federal, state and county governments has increased enormously. The most recent estimate is approximately \$36 Billion/year.

With hundreds of billions of dollars invested over the past three decades, the actual result has been a further decline in the areas of society that the psychiatric influence has permeated, particularly the education and the criminal justice systems.

The fact that psychiatry cannot survive without the majority of its revenue coming from government funds attests to its ineffectiveness. A thorough investigation into the waste of government funds by psychiatry would be very revealing.

Starting in the mid-1980's the psychiatric industry attempted to survive "on it's own", through private, for-profit psychiatric hospitals. By 1990, insurance executives were complaining that the costs of psychiatric care were skyrocketing compared with other medical costs, with admissions for adolescents alone to psychiatric facilities rising 450% from 1984-1987.

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The scandal rocked the private, for-profit psychiatric hospital industry, resulting in further investigations by the Federal Trade Commission, the FBI, the GAO and the Inspector General's Office of the Department of Health and Human Services.

In addition, ten major insurance companies filed RICO lawsuits against one of the hospital chains. As a result of these efforts, numerous private hospitals went out of business since they could no longer fill their beds through illegal means.

Given the fact that the psychiatric field, left to its own, has shown it cannot and will not restrain itself from taking the highest insurance benefits it can gain, even if it means making up diagnoses to fit the insurance plan, any proposed standardized minimum health benefits package should exclude coverage for psychiatric care. It is far too costly to mandate coverage of this type in a minimum benefits package. Rather, it should be made optional for an additional fee to be paid by those needing the coverage, thereby satisfying those who want it without burdening the employer with the added cost of providing it for everyone.

Another cost containment activity which the federal government could implement in the area of psychiatric care and alcohol and drug treatment would be to either hold these areas to the same reimbursement system of Diagnosis-Related Groups (DRGs) as other Medicare programs, which sets rates of payment to hospitals in advance for service delivery, or to base their reimbursement strictly on outcome-based data. This would be in contrast to the payment method used now which reimburses the hospitals based on the costs incurred during hospitalization.

#### Mandatory Physical Examinations

Large numbers of so-called "mental patients" are not screened for active physical ailments and diseases before admission to psychiatric facilities. In many cases, the undiagnosed physical problems are the direct cause of the so-called mental disorder.

A California study entitled "Medical Evaluation of Psychiatric Patients", published in the Archives of General Psychiatry, Vol 46, August 1989, estimated that of the more than 300,000 patients treated in the California public mental health system in fiscal year 1983 to 1984, 45% had active, important physical disease. The mental health system had recognized only 47% of the study patients' physical diseases, including 32 of 38 diseases causing a mental disorder and 23 of 51 diseases exacerbating a mental disorder. The study went on to suggest that patients treated in the public sector mental health facilities should receive careful medical evaluations upon admission and before treatment.

The Citizens Commission on Human Rights recommends that mandatory physical examinations by a competent medical doctor, not a psychiatrist or other mental health care provider, be implemented for anyone who is scheduled to enter a psychiatric facility. This would include but not be limited to complete blood work-ups, testing for all types of allergies including food allergies, and mandatory treatment for the physical ailments found by competent physicians before admission to the psychiatric facility.

#### FDA ADVISORY COMMITTEE REFORM

The Food and Drug Administration is coming under ever-increasing pressure to get new life-saving drugs on the market faster. With the attention of the general public focused on deadly diseases such as AIDS and cancer, and the FDA's current drug approval process taking an average of seven years, there are serious questions being raised as to why it takes so long for FDA to approve these drugs.

A recent survey of congressional aides serving on committees and subcommittees with jurisdiction over the FDA showed that there are mixed reactions concerning speeding up the drug approval process. The overwhelming majority are in favor of FDA speeding up the drug approval process for life-saving drugs, but not at the expense of protecting the safety of Americans.

The GAO reported in 1990 that of the 198 drugs approved by the FDA between 1976 and 1985 for which data was available, 102 (or 51.5 percent) had serious postapproval risks, as evidence by labeling changes or removal from the market.

Of the psychiatric drugs approved by the FDA during that time, GAO determined that 60 percent had serious postapproval risks, defined as adverse reactions that could lead to hospitalization, increase the length of hospitalization, cause severe or permanent disability, or even death.

While CCHR supports speeding up the drug approval process for life-threatening physical diseases, it does not support it at the expense of protecting the health and safety of Americans from dangerous psychiatric drugs.

Psychiatric drugs are some of the most powerful substances allowed on the market by the FDA. Documented evidence shows that thousands have suffered permanent neurological damage and death due to many of these drugs, suffering that could have been prevented with proper FDA controls.

Because of the nature of these substances, there are three reforms of the FDA's drug approval process which the Citizens Commission on Human Rights recommends.

CCHR's reforms of the FDA's drug approval process are:

- A) Parallel pre-market clinical trials be conducted by an independent laboratory contracted by the FDA. The purpose of the independent tests would be to replicate and verify the safety and efficacy of drug tests done by a manufacturer. This would ensure that FDA in their approval process would have two sets of data to compare instead of just the manufacturers' data. This could significantly cut down the time it takes to approve new drugs.
- B) Strengthening the post-marketing review of suspect drugs by:
  - 1) Requiring an automatic, independent clinical review and study of a drug within the first two years if the adverse drug reaction reports filed with the FDA totaled 2,000 or more;
  - 2) Requiring an automatic, independent review and study of a drug if the percentage of deaths, suicides, attempted suicides, or permanent disabilities (taken cumulatively) in the adverse reaction reports are higher than the national average for deaths, suicides, suicide attempts and permanent disabilities (taken cumulatively) linked to the disease or ailment being treated by the drug;
- C) Abolishing all FDA Advisory Committees having to do with psychiatric drugs and putting in their place a Drug Safety Oversight Commission, similar to the British Royal Commission System. This commission would meet when there are questions of a serious nature as to the safety and efficacy of a drug currently on the market brought to light by the FDA's adverse reaction reporting system or other means such as an independent review.

The Drug Safety Oversight Commission members would be appointed by the President and chaired by a retired federal judge. Commission members would include those recommended by both the House and Senate, as well as representatives selected from various medical specialties and public citizen groups. As an alternative, CCHR suggests the appointment of an independent counsel to conduct the investigation.

The Drug Safety Oversight Commission would have special powers such as:

- 1) Legal powers to subpoena witnesses;
- 2) Legal powers to place witnesses under oath;
- 3) Report its findings and recommendations to the President, Congress, the Secretary of HHS and the Commissioner of FDA.
- 4) Authority to recommend civil and criminal proceedings be initiated by the Department of Justice, and/or other law enforcement agencies.



Additionally, a mechanism allowing private citizens and organizations to petition the Congress and HHS to convene such a commission for a review of a drug, or a class of drugs, should be included.

#### CONCLUSION

In sum, CCHR strongly supports the efforts to reform a health care system that is spiraling out of control. CCHR also appreciates the difficult decisions facing the Administration, the Congress, the health care providers, the insurance industry, employers and consumers. It is therefore imperative, in our judgement, that any mandated coverage be limited in both coverage and cost to only the most essential and major medical type problems. CCHR looks forward to making a meaningful and responsible contribution to that effort.

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April 15, 1993

Janice Mays  
Chief Counsel and Staff Director  
Committee on Ways and Means  
1102 Longworth House Office Building  
Washington, DC 20515

Dear Ms. Mays:

I speak on behalf of several thousand clinically trained clergy and lay ministers of all faiths and their patients/clients in my capacity as chair of the public issues task force of the Congress on Ministry in Specialized Settings.

After my 20 year ministry as a clinical chaplain and pastoral educator in a large state mental hospital, two university teaching hospitals, a community mental health center, and a Catholic community hospital, I am more convinced than ever that quality spiritual care, provided by a trained ministerial member of the treatment team, is a vital part of healing and wholistic health care, and, therefore, must be included in the national health care benefits funding plan.

The pastoral care and counseling movement in this country, transcending traditional faith boundaries, has in increasing fashion over the last half century provided a dedicated cadre of religious caregivers who quietly but effectively serve on the treatment team as full partners with their professional colleagues in medicine and the behavioral sciences.

In preparation for their clinical ministry they have submitted their caregiving work to the careful (and sometimes painful) scrutiny of their peers via certifying professional bodies such as the American Association of Pastoral Counselors, the Association for Clinical Pastoral Education, the Association of Mental Health Clergy, the Catholic Health Association, the College of Chaplains, and the National Association of Catholic Chaplains. (See Enclosure 1, complete COMISS list.)

The potential contribution of these spiritually centered caregivers is virtually unlimited. Although they (we) are notoriously resistant to documenting and reporting their (our) work, there are informative studies. To avoid information overload here I have chosen only three research efforts for your immediate consideration, each representing a major thrust. Others works are available for further reference.

A focus for the 1960s and 70s was the relationship of acceptance and healing. In a replication study with heart surgery patients Mills and others found a high correlation between chaplain interventions, acceptance, and an enhanced healing process (higher survival rate, fewer complications, less medication required, normal diet within 48 hours, minimal thinking disorder, earlier hospital discharge). (Enclosure 2)

Ironically, it was a medical doctor, Elisabeth McSherry, who led the clinical pastoral research "way" in the 1980s in her recognition of the ways in which quality pastoral care is subtly but powerfully cost effective. Dr. McSherry's essential thought is captured in the enclosed paper, presented in 1984 at the National Walter Reed Medical Conference. (Enclosure 3)

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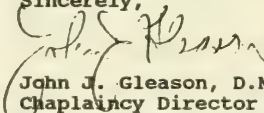
The current research focus is upon perceptions of the value of chaplaincy, but the strongest work so far seems to be that of Parkum, also reported in 1984. He surveyed patients in six hospitals and found that pastoral care services made a strong impact, especially in the context of expressive versus instrumental social orientations. (Enclosure 4)

Most of these pastoral professionals are paid by the institutions they serve or by fee for service. Should their invaluable contributions to health and healing be omitted from the budget planning of the health care reform task force, the outcome would involve much more than the loss of paid positions. The opportunity to attain true wholism in U.S. health care in the years ahead would be severely hampered, if not completely lost.

At relatively small overall cost, the intentional focus on the powerful spiritual aspect of health and healing, offered in a completely nonsectarian manner by these qualified and caring clergy and laity, can continue to be available to our citizens, allowing the U.S. to move toward an ever more humane, wholistic system of health care delivery.

Please let me know how I can further inform you, perhaps with more detail on pastoral counselor and chaplain professional standards, faith group endorsement, and related matters. And thanks for your availability to listen to our concerns. God bless!

Sincerely,



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Enclosures

[Attachments have been retained in Committee files.]



**DEPROGRAMMING SURVIVORS NETWORK**  
*"Strengthening Family Ties Through Dialogue"*

STATEMENT OF DR. ISSAC W. BROOKS, JR  
 PRESIDENT, DEPROGRAMMING SURVIVORS NETWORK

TO THE SUBCOMMITTEE ON HEALTH  
 COMMITTEE ON WAYS AND MEANS  
 U.S. HOUSE OF REPRESENTATIVES

**Hearing on Health Care Reform:  
 Consideration of Benefits for Inclusion  
 In a Standard Health Benefit Package**

I want to first acknowledge the important job being done by this Subcommittee. The health of the citizens of our country is a vital issue, one on which the future well-being of this nation depends.

It is with this in mind that I, on behalf of the Deprogramming Survivors Network (DSN), am submitting this statement. The Deprogramming Survivors Network is a group of academics, religious leaders and victims of "deprogramming" from around the country whose purpose is to educate the public regarding non violent solutions to family upsets over religious conversions to another faith. DSN is dedicated to strengthening family ties through dialogue. DSN is opposed to solutions involving kidnapping, or involuntary detention.

"Deprogramming" by definition and practice is the forcible abduction and/or forcible physical detainment of an adult in order to force the person to give up deeply held beliefs. In many cases the person is literally "snatched" off the street, shoved into a waiting van, driven across state lines, imprisoned for days, weeks or months in a secluded place with windows boarded up and guards on duty night and day. If escape is tried the person is reatled to the ground and locked up again. During the deprogramming the person is psychologically raped. One woman after weeks of being imprisoned managed to escape her mountain cabin prison. She jumped into a river, nearly drowning in her desperate attempt to flee her "deprogrammers".

It is hoped that this statement will help streamline the difficult job faced by the members of this Subcommittee to find projects vital to the Health Care Reform package by shedding light on projects which are NOT NEEDED.

**SUMMARY**

The Deprogramming Survivors Network (DSN) is alarmed by two statements provided to your Subcommittee; one by Dr. Margaret Singer, advisor to the Cult Awareness Network (CAN) and American Family Foundation (AFF) and another statement -- jointly submitted -- by AFF president Herbert Rosedale and CAN president Patricia Ryan.

Unsupported by objective research and information, these statements attempt to establish the existence of a questionable, widespread mental health problem for which we should expend additional tax dollars at a time when Americans are very concerned about the growing national deficit.

Specifically, they advocate funding of mental health services for adults who have left churches, religious organizations and groups, Singer designates as "cults."

It is the studied position of DSN that federal funding for such a proposal would not only be a waste of taxpayer dollars but would become an unconstitutional entanglement of the federal government in the arena of personal religious beliefs and association.



The Members of the Subcommittee should understand that the Singer and Rosedale statements are from controversial individuals and organizations which have a history of: (1) promoting hatred and distrust of a myriad of new and established churches and religious organizations through the dissemination of wild inaccuracies and distortions; (2) advocating the suspension and erosion of First Amendment freedoms and (3) promoting discredited theories of "brain washing" and "mind control" and supporting the practices of "deprogramming."

The Cult Awareness Network, for example, was founded in 1974 as the Citizens Freedom Foundation (CFF) with large assistance from Ted Patrick, the father of kidnapping/deprogramming, in order to expand on Patrick's illegal activities. Patrick has been convicted three times and banned from Canada for his abductions of adults.

The practice of deprogramming has been widely condemned by both religious organizations and civil liberties groups.

Further, the "mind control" theories of Margaret Singer, which form the basis for the statements submitted by Singer and Rosedale as well as the justification for countless illegal kidnappings/deprogrammings, have been discredited by professional associations and rejected by federal and state courts.

Singer and Rosedale are using the smoke screen of the invented "cult veteran" problem to request federal funds to finance their own project to lend credibility and legitimacy to controversial activities which have been professionally discredited by religious leaders, academics, civil liberty and law enforcement officials -- namely the forcible de-conversion of religious adherents.

Singer and Rosedale seek to replace the forcible kidnappings of the past with federally financed and thus officially sanctioned involuntary mental health commitments. Such commitments would lead to the use of the full range of psychiatric weapons -- potent drugs, electro-shock and isolation -- to effect the religious de-conversions illegally done or attempted over the past two decades.

It is the position of DSN that such harmful use of federal funds should be vigorously opposed.

#### **A NON-EXISTENT HEALTH CARE ISSUE**

Both of these statements claim that there is a large group of individuals, formerly members (cult veterans) of what they call "destructive cults," who desperately need health care but have no health insurance or personal finances with which to obtain it.

Both of these statements recommend that a standard health care package include programs to handle the mental and physical "rehabilitation" needs of these individuals who have "exited" from these alleged groups.

They offer no hard statistics to support their claims. Facts to the contrary exist in published academic studies. One study done by Dr. James Lewis, sociologist with the Institute of American Religions in Santa Barbara, CA found that those individuals who leave a group voluntarily are mentally sound and those who are "deprogrammed" or forcibly coerced to leave often have emotional problems.

#### **PSYCHOLOGICAL THEORIES DISCREDITED**

The psychological theories of "thought reform" and "coercive persuasion" were used by Margaret Singer some 10 years ago in court rooms as she presented herself as an expert witness against various religious and other groups. These theories have since been discredited and rejected by the American Psychological Association and the American Sociological Association and by various federal and

state courts. As an advisory board member to CAN and AFF, Ms. Singer, has sought over the years to obtain a livelihood by offering her services as an expert witness.

Singer has a record of poor research and conclusions. Her first testimony was in the Patty Hearst trial. Dr. Richard M. Bailey submitted a critique of the study that Singer had done of Hearst. His conclusion in 1976 is a preview of later reports from the APA and more recent judicial orders to exclude her testimony.

Dr. Bailey, in USA vs Patricia Campbell Hearst concluded, "A.) Dr. Singer's analysis does not derive from either of the accepted disciplines for stylistic analysis.... B.) Her self-devised criteria are demonstrably inadequate and are applied with astonishing indifference to the criteria of clear research methodology and potential replicability."

#### UNCORROBORATED STATISTICS PAINT FALSE PICTURE

The uncorroborated statistics used by CAN and AFF are used in such a way as to paint an alarming picture. Singer cites an estimate of 5,000 "such groups" in her Subcommittee statements. This figure is not based on any study and when asked to produce this list can not. Neither CAN nor AFF have a list of the groups they consider to be cults. CAN's promotional material only states that the list they have is a list of groups people have written to them asking about.

These numbers are specious and not in alignment with those cited by religious scholars. According to J. Gordon Melton, author of the Encyclopedia of American Religions, for example, "The United States is currently home to more than 1,500 different primary religious organizations -- churches, sects, cults, temples, societies, missions." J. Gordon Melton, Encyclopedia of American Religions Fourth Edition, 1993, Gale Research Inc, page 1.

#### CULT AWARENESS NETWORK/AMERICAN FAMILY FOUNDATION

The practices of "deprogramming" or kidnapping and physical detention of an individual are practiced and / or condoned by both CAN and AFF.

Herb Rosedale's American Family Foundation shares many of the same advisory board members as CAN, and supports efforts to undermine the First Amendment rights of groups they personally do not approve of.

The practice of kidnapping/deprogramming has been condemned by many. The following are just a few:

- \* The National Council of Churches of Christ in the USA: Resolution on "Deprogramming" Adopted by the Governing Board on February 28, 1974, "Religious Liberty for Young People Too".
- \* American Civil Liberties Union (ACLU): Adopted by unanimous vote January 19, 1977.
- \* The United Methodist Church: The Book of Resolutions 1980, Page 49.
- \* The Presbyterian Church USA: "God Alone is Lord of the Conscience", Policy Statement Adopted by the 200th General Assembly (1988) Page 39.
- \* Dr. Thomas Szasz, Professor of Psychiatry, Syracuse University New York, March 1976.
- \* New England Psychological Association at Clark University, Worcester, MA.
- \* Baptist Joint Committee on Public Affairs
- \* Archbishop Fulton Sheen
- \* Rev. Billy Graham
- \* Dr. J. Gordon Melton, Institute for the Study of American Religions.

Congressman John Conyers in an April 20, 1988 report to his Committee on the Hate Crimes Statistics Act of 1988 which was passed into law noted:

"In recent years, several of the non-traditional religious groups such as Scientologists, Buddhists, Fundamentalists, and Evangelicals, have experienced an increase in the harassment of their members by anti-cult groups. Abductions of members to 'deprogram' them - to get them to renounce their religious beliefs - are well documented. These attacks have provoked the concern of some mainstream churches, leading them to join the targeted religious groups in an effort to educate the public and the police about the problem."

Kidnapping for the purpose of changing someone's religious faith has also been severely criticized by U.S. District Court for the Eastern District of Virginia Judge T.S. Ellis, III in deprogramming conspiracy case, United States of America vs Edgar Newbold Smith, Galen Kelly, et al stated to Cult Awareness Network deprogrammer Galen Kelly on December 31, 1992,

"...the trial ought to be a clear message to you that under no circumstances is it ever justified to snatch, lift, or pull anybody off the street against their will however wacky you may think their views are...however laudable you may think the purpose is, it is not a justification for doing that."

Over the years victims of "deprogramming" have included members of the Catholic Church, the Episcopal Church, the Church of Jesus Christ of Latter-day Saints (Mormons), The Church of Christ, Scientist (Christian Science), the Greek Orthodox Church, the Disciples of Christ, Assemblies of God, newer religion and many other independent Christian denominations.

Deprogramming Survivors Network strongly denounces the practices and theories of CAN and AFF and seeks to ensure that such "hate crimes" are not perpetuated through the court systems or through legislation.

#### GOVERNMENT FUNDING FOR ANTI RELIGIOUS ACTIVITIES - UNCONSTITUTIONAL

Rosedale's statement concludes with the statement that the governments of at least seven countries have contributed funds to "cult educational and research organizations."

What he omits, however, is the fact that where such funding has been challenged by religious groups who have been targeted by these so-called "educational and research organizations," courts have resoundingly found such funding to be illegal. -- To name two: March 27, 1992, decision of the Federal Supreme Administrative Court of Germany. Ruling stated that funding of the private anti-religion group known as "AGPF" by the Federal Ministry of Youth, Family and Health was illegal. On August 26, 1992, an injunction was issued by the Administrative Court of Stuttgart against any further funding of ABI, a local anti-religious group, by the Stuttgart government.

#### VIOLETIONS OF FIRST AMENDMENT

In the United States, it would of course be a violation of the First Amendment for any government funds to be allocated to organizations, such as CAN and AFF, that are known to advocate the destruction of religious groups and the severing of individuals' ties to religious groups.

#### CAN/AFF JUDGEMENT CLOUDED BY RELIGIOUS PREJUDICE

Professor James T. Richardson and Brock K. Kilbourne describe the phenomena in a paper entitled Cultphobia.

"... a kind of extreme fear reaction to new religions or cults, which is highly resistant to inconsistent and contradictory evidence.... Such individuals are prone to make very heavy use of atrocity tales about cults to justify their beliefs and feelings and to convert others to their view. In these cases, as soon as one atrocity tale is debunked, another one quickly develops to take its place.

"... Yet in light of the growing body of empirical evidence being reported to refute the alleged totally harmful effects of new religious affiliation, it is difficult at times to understand the sometimes obsessive, irrational fear of the so-called cults." Further, "... the concept of cultphobia is similar in substance to any of the other wide variety of phobias reported in our culture. Like other phobias, it constitutes a persistent fear of an object ... that presents no actual danger to the person..."

This paper goes on to discuss different degrees of severity of cultphobia, and the seriousness of severe reactions "because of their consequences for both the sufferer and the sufferer's feared object. They resort to the obsessive telling of atrocity tales, encourage or practice forced deprogrammings, and/or initiate a 'vendetta' to regulate/control cultic activities at every level of public life (i.e., local, state and federal)." Cultphobia, Brock K. Kilbourne, James T. Richardson, as published in Thought Vol. 61, No. 241, June 1986.

Authorities, such as Dr. Richardson are sincerely concerned about the theories used by CAN and AFF in their statements to the Subcommittee saying that "victims" are not only from religious "cults" but that "cults form around many themes, including political, racial, and psychotherapy." These theories when disseminated through the media and given validity in legislation set a further climate for the execution of hate crimes.

In another paper, Dr. Richardson specifically discusses Margaret Singer's role in this "cultphobia" by going so far as to classify members of new religions as suffering from some form of mental illness. He is quick to point out that the American Psychological Association's response to her theories was that they "lack the scientific rigor and evenhanded critical approach necessary for APA imprimatur." Battling for Legitimacy: Psychotherapy and the New Religions in America, James T. Richardson, Ph. D., Department of Sociology, University of Nevada, May 1989. Prepared for Pacific Sociological Annual Meeting in Reno, Nevada, 1989.

#### CONCLUSION

The health care concerns of America are so vast and urgent that giving attention to the virtually non-existent problem of "cult veterans" would unnecessarily divert federal funds from other needed problems and would pose the additional danger of federal entanglement in religious affairs and increase federal exposure to civil rights litigation.



## REFERENCES

## Concerning psychological theories of Margaret Singer:

## 1. American Psychological Association (APA):

The APA described the final report her task force submitted on "deceptive and indirect methods of persuasion and control" after three years of deliberation, as follows: "In general, the report lacks the scientific rigor and evenhanded critical approach needed for APA imprimatur." The APA Board had consulted two independent experts in arriving at their conclusion. The APA Board put the task force members on notice that their appointment to the task force was not to be used to imply that the APA in any way supported the positions put forward by the task force. The American Psychological Association, prior to its resounding rejection of Singer's report, endorsed a position refuting her "coercive persuasion" theory in an amicus brief before the California Supreme Court in Molko v. Holy Spirit Association.

## 2. District of Columbia Court of Appeals:

Singer gave testimony central to the case of Kropinsky v. World Plan Executive Council. The District of Columbia Court of Appeals in August 1988 overturned the case due to Singer's testimony, saying, "Kropinski failed to provide any evidence that Dr. Singer's particular theory, namely that techniques of thought reform may be effective in the absence of physical threats or coercion, has a significant following in the scientific community, let alone general acceptance."

## 3. Fourth Appellate District Court of Appeal of California:

In 1989, in the case of Robin George v. International Society for Krishna Consciousness of California, Singer was hired to testify that Robin George had been "brainwashed" into joining the Krishna movement and was not operating on her own free will.

The Fourth Appellate District Court of Appeal of California, saw through Singer's "theories" and concluded that Singer's testimony was no more than an attempt to bolster a civil litigant's argument to collect damages: "... Robin's brainwashing theory of false imprisonment is no more than an attempt to premise tort liability on religious practices the Georges find objectionable. Such a result is simply inconsistent with the First Amendment."

## 4. U.S. District Court Northern District of California:

In 1990, U.S. District Court Judge D. Lowell Jensen in US v. Fishman reviewed in detail the history of Singer's controversial expert witness status, including voluminous submissions on Singer's behalf to allow her to testify and promoting her credentials. Judge Jensen barred her from testifying, concluding that her views were not generally accepted within the scientific community both as to merit and to methodology: "The evidence before the court...shows that neither the APA [American Psychological Association] nor the ASA [American Sociological Association] has endorsed the views of Dr. Singer and Dr. Ofshe on thought reform. The APA found that Dr. Singer's report lacked scientific merit and that studies supporting its findings lack methodological rigor."

## 5. U.S. District Court in Washington, D.C.:

The US District Court in DC in the case Patrick Ryan v. Maharishi Yogi, despite applying the less rigorous civil standard than the criminal standard that was applied in the Fishman case, found that Singer's expert testimony had failed to gain substantial acceptance within the scientific community. Judge Oliver Gasch refused to allow Singer to testify.

## 6. California Superior Court:

Judge Stuart Pollack, California Superior Court judge, stated, "[Singer's declaration] plainly contained no competent evidence concerning the state of mind of the plaintiffs."

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STATEMENT OF THE  
GASTROENTEROLOGY LEADERSHIP COUNSEL  
(COMPOSED OF THE AMERICAN COLLEGE OF  
GASTROENTEROLOGY, THE AMERICAN GASTROENTEROLOGICAL  
ASSOCIATION, AND THE AMERICAN SOCIETY FOR  
GASTROINTESTINAL ENDOSCOPY)  
TO THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
ON  
HEALTH CARE REFORM  
CONSIDERATION OF BENEFITS FOR  
INCLUSION IN A STANDARD HEALTH BENEFIT PACKAGE

The Gastroenterology Leadership Council is a working coalition of scientific, educational organizations in the field of gastrointestinal conditions and diseases composed of The American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy. The Council appreciates the opportunity to submit testimony for the official hearing record of the Ways & Means Committee's recent hearing on Health Care Reform: Consideration of Benefits for Inclusion in the Standard Health Benefit Package.

Colorectal cancer is the second most frequent cancer killer in America, claiming the lives of 57,000 persons annually. Preventive care and early detection are of paramount importance in improving survival prospects and in saving costs. Current American Cancer Society and National Cancer Institute (NCI) guidelines recommend annual fecal occult blood testing and flexible sigmoidoscopy every three to five years to screen individuals over fifty years old for colorectal cancer.

The purpose of our statement today is to urge Congress to include colorectal cancer screening, by flexible sigmoidoscopy and fecal occult blood testing, and surveillance by colonoscopy, in any basic benefit package developed under federal auspices related to the Congressional legislation on national health care reform. Specifically, any basic benefit package should cover annual fecal occult blood testing and flexible sigmoidoscopy as the general screening mechanism of choice every 3-5 years for the asymptomatic patients over 50 years of age who have no other predisposing factors. Colonoscopy would generally be the surveillance mechanism for the asymptomatic patient who by virtue of family history, prior experience, or chronic history with a digestive disease condition or other predisposing factor would be placed at higher risk for the disease.

We commend this Committee and the Chairman's leadership in H.R. 200, which contains a provision for inclusion of fecal occult blood testing and flexible sigmoidoscopy for screening purposes. Clearly this legislation marks a major step forward, particularly since historically colorectal cancer screening of asymptomatic patients generally has been excluded from Medicare reimbursement.

Definitions:

**Fecal occult blood testing** - a simple chemical test performed on a stool smear to detect amounts of blood that are too small to be seen.

**Flexible sigmoidoscopy** - examination with a flexible instrument of the lower one-third of the colon within which 50-60% of polyps and cancers occur.

**Colonoscopy** - use of a longer flexible instrument capable of examining the entire large bowel. Colonoscopy is the most accurate method of examining the large bowel and has the additional advantage of allowing biopsy of suspected abnormalities and removal of most colorectal polyps which are the precursors of almost all colorectal cancers.

**Screening** - the use of a simple, inexpensive test applied to the average risk population designed to identify those individuals in that population more likely to have colorectal cancer. Since screening tests may not, in themselves, be diagnostic, further evaluation is usually required. Some individuals in the population have a high enough risk for colorectal cancer that periodic diagnostic evaluation is warranted. This process is referred to as **surveillance**.

Although legislation has been introduced periodically to expand Medicare benefits to cover such screening, currently Medicare precludes reimbursement for flexible sigmoidoscopy and fecal occult blood testing. As we move forward toward national health reform, it is shortsighted not to cover the most effective early cancer screening methods. Current Medicare rules also preclude reimbursement for colonoscopic surveillance for individuals at higher than normal risk. Some individuals are at higher risk for colorectal cancer to warrant the periodic examination of the entire large bowel with colonoscopy, rather than simple screening with flexible sigmoidoscopy. This group includes patients who have a family history of colon cancer, a past personal history of colorectal cancer or polyps or long-standing ulcerative colitis.

## Conclusion

In closing, Mr. Chairman, we perceive that the standard benefit package is the most important component of managed competition/health care reform, and we think Congress should specifically address this issue in significant detail.

Establishing a "standard benefit package" will make it easier for consumers to compare costs of various insurance programs, if benefits are identical. Moreover, as others have suggested, the standard benefit package also might be used to define the limits of what health insurance payments are deductible. Consumers could choose to buy additional coverage, but it may not be subsidized by the federal government through tax deductibility. Finally, Congress should recognize a certain aspect of rationing may be involved in setting the standard benefit package. Similar to the experimental plan in Oregon, the approach to controlling overall health care costs could develop as "if you want something not in the standard benefit package, you can have it only if you can pay for it!"

The Gastroenterology Leadership Council greatly appreciates the opportunity to present our concerns relating to the standard benefits package under health care reform. We strongly urge and encourage the Committee to include colorectal cancer screening -- by fecal occult blood test and flexible sigmoidoscopy, and surveillance colonoscopy of asymptomatic, higher than normal risk groups -- in the national standard benefit package. We would be pleased to respond to any questions which Committee Members or staff may have. Thank you.



## STATEMENT OF THE HOME CARE COALITION

### NATIONAL HEALTH CARE REFORM – MANAGED COMPETITION HOME HEALTH CARE PROPOSALS

#### EXECUTIVE SUMMARY

#### HEALTH CARE DELIVERY IN THE YEAR 2015

My 15-year old son is home ill today. Nothing serious. We could tell a couple of days ago that he was coming down with something based on adverse readings from our home VSMS (Vital Sign Monitoring System). We primarily use our VSMS to track prevention-oriented data, such as cholesterol level, calorie intake, temperature, weight, blood pressure, chemical/nutritional balance (based on VSMS analysis of blood and urine samples), and cardiac analysis from our VSMS EKG. But, the daily printout showing 30-day trends indicated that antibodies were forming to combat something. We quickly accessed our PC-based Clinical Indications and Referral System (CIRS). This is an expert system designed for use by those without a medical background. By combining the data from the VSMS along with subjective responses to symptom-related questions, we were advised that my son's clinical indications did not suggest a serious illness, and that a visit to our physician was not necessary at this time. We do, however, need to re-evaluate, based on updated data, every eight hours. . . . we are fortunate to have VSMS, CIRS and PRG in our home . . . .<sup>1</sup>

The health care system of 2015 described above will arrive someday. Indeed, many features of this system exist today. The framework for national health care reform must not only reflect the health care delivery system of yesterday and today, but also must not create a chilling effect on the health care delivery system of tomorrow. Indeed, any national health reform proposal should provide financial incentives to encourage the continued development of less costly, high-quality alternatives to the traditional way in which health care services have been delivered and/or covered in the United States. We must begin to substitute the order ADMIT TO HOME, for the currently over-utilized one, i.e., ADMIT TO HOSPITAL without requiring a patient to jeopardize health care coverage and in order to maximize patient satisfaction.<sup>2</sup>

The home health care proposals discussed herein<sup>3</sup> are designed to maximize flexibility in coverage of health care services regardless of delivery setting (that is, the hospital, the patient's home, or other appropriate setting) as well as to empower the consumer-patient in the health care decision-making process. With respect to the former, that is, the delivery setting, in order to effectuate one of the main goals of any health care reform -- to provide access to high quality, cost-effective care -- medically appropriate health care services and items must be covered not only when delivered in facilities, such as hospitals, but also when delivered in patients' homes or other medically appropriate settings. We must begin national health reform today where lessons from Medicare and Medicaid leave off. We must avoid the delivery "cubbyholes" established under these federal programs where status quo health care delivery in 1965 became the framework, and these federal programs were unable to adapt quickly to the ingenuity in the health care industry.

We must include lessons that have been learned from the private health insurance sector as well. Indeed, the private sector has been adaptive and creative in its coverage of home health care services in recent years, particularly as a part of its managed care initiatives. This is because of the private sector's ability not only to target the issue but also to have the flexibility to implement changes without significant delay.

<sup>1</sup> Douglas Leland, Vice President, Intracorp "Health Care Delivery in the Year 2015: Today's Reform Decisions are Shaping the Future", paper presented at the American Managed Care and Review Association Conference, October 19, 1992.

<sup>2</sup> Dr. Ron Pion, ASTA Care Communications

<sup>3</sup> The proposals discussed in this paper are based on Managed Care Competition Act of 1992, H.R. 5936 and S. 3299.

With respect to the latter, consumer empowerment, national health care reform needs to include provisions that would empower consumers to share in the health care delivery decision-making process. Jack Wennberg of the Dartmouth Medical School says, "the best [medical] treatment is the one patients choose once they've received full, *impartial* information"<sup>4</sup> He further says that "[s]hared decision-making, backed up by hard outcomes data, leads to better care at a fraction of the current cost."<sup>5</sup>

To further document these objectives, we have suggested modifications for the Managed Competition Act of 1992, proposed legislation currently receiving widespread attention. The following are the basic principles which underlie our proposed home health care revisions

1. *Empower eligible individuals not only with the freedom to choose the types of treatments that they, and their health care professional, believe would best meet the individuals' needs, but also with the freedom to choose the setting where health care are delivered; that is, whether the health care services are provided in a health care facility, in the patient's home, or in other health care settings.*
2. *Guarantee individuals' freedom of choice in selecting the health care provider with whom they are most comfortable by requiring accountable health plans ("AHPs") to provide eligible individuals with access to care from any health care provider in the service area, even if the health care provider is not under agreement with the AHP.*
3. *Ensure that the uniform set of effective benefits covers a broad array of health care services even if delivered in the patient's home.* These health care services must include, but not be limited to, the appropriate use of physicians, nurses, physical therapists, respiratory therapists, and other health care professionals, items, technologies, equipment, infusion therapy, pharmaceuticals, and supplies that are medically necessary to treat or maintain the individuals' medical condition as well as to attain or maintain the individuals' capability for independence and for self-care, including education for either the patient or the patients' caregivers;
4. *Require the National Health Board to adopt minimum credentialling standards for all health care providers as a minimum indicia to ensure that the quality of health care services provided by the health care provider is adequate.* Such credentialling standards could be those established by a recognized accredited public or private organization, those recognized by the Medicare program under title 18 of the Social Security Act, or those recognized by State law or regulation; and
5. *Ensure information is provided to individuals and employers that permits them to evaluate AHPs on a comparative basis, that is, provide information that describes not only the types and outcomes of treatment, but also the types of health care providers covered by the AHP as well as the settings in which such covered health care services will be delivered and covered.*

The proposed home health care revisions have been drafted to define key terms to reflect the current health care delivery environment as well as to accommodate future health care delivery environments. For instance, in the past, the term "provider" has often been used to refer only to "institutional settings." However, in today's health care market, many health care entities are able to deliver health care services to patients in a variety of settings. Yet, the Managed Competition's proposed legislation, as currently drafted, uses the term "provider" to continue this facility bias. Thus, in our proposals, the legal term "provider" would be broadened to encompass all health care entities that render health care services, such as hospitals, skilled nursing facilities, home health agencies, home medical equipment suppliers, and home infusion therapy providers

4 "Dr. Video: How Best to Decide What Patients Need", Editorial Notebook, *New York Times*, Sunday, December 13, 1992

5 Id.

The proposed home health care revisions also have been drafted to ensure that the bill encourages the coverage and utilization of health care services capable of being provided safely and efficaciously outside of the institutional setting. Indeed, a recent report issued by the Office of Technology Assessment<sup>6</sup> stated that Medicare's "benefit structure ... tends to discourage the most independently functional patients from leaving the hospital." The report further states that the Medicare program's lack of coverage for physician case management services (such as telephone or administrative time) "is a disincentive for physicians to discharge some patients to home care under the current [Medicare program]." This limitation or institutional coverage bias should not be perpetuated in any proposed national health care reform measure.

Other recent reports discuss the cost-effectiveness of home health care services. For instance, a 1991 Lewin/ICF study<sup>7</sup> found that "full realization of the potential of home health care services and home medical equipment services can achieve significant cost savings as well as improve patient satisfaction." Other reports also have evaluated whether people accept or prefer home health care services. These reports tend to find that people not only accept home care, but also actually prefer receiving health care services in their home when it is medically appropriate.

Health care services provided to patients in the home are cost-effective, permit patients to continue to live independently, provide the least disruption to the family, and function therapeutically as well. That is why it is important not to have a national health care reform proposal which could create a bias against home health care services by focusing only on treatment of acute care conditions. Home health care services very often serve the ever-growing number of chronically ill people in America. Consistent with the objective of providing access to efficient and effective health care, health care services provided in the home should not only be included in any national health reform minimum benefits package, but also should be encouraged.

#### FOR MORE INFORMATION CONTACT

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<sup>6</sup> U.S. Congress, Office of Technology Assessment, *Home Drug Infusion Therapy Under Medicare*, OTA-H-509 (Washington, D.C.: U.S. Government Printing Office, May 1992).

<sup>7</sup> Lewin/ICF *Economic Analysis of Home Medical Equipment Services*, May 29, 1991.

## HEALTH CARE REFORM -- MANAGED COMPETITION HOME HEALTH CARE PROPOSALS<sup>\*/</sup>

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This paper provides a series of proposed home health care revisions to the Managed Competition Act of 1992, H.R. 5936 focusing on home health care in the broadest sense.<sup>8</sup> Following a brief overview, the remainder of this paper describes in detail each technical amendment proposed. For each subtitle of this pending legislation, the following information is provided:

1. **Summary of Current Draft** -- This section summarizes the pertinent provisions currently found in the bill as it was introduced
2. **Purpose of Home Health Care Provisions** -- This section highlights the reasons underlying the need for the proposed revisions
3. **Technical Amendments** -- This section, by page and line, provides the draft language that is needed to effectuate the proposed revision.

### *OVERVIEW*

This section provides a brief summary of the Managed Competition Act of 1992. The following section highlights the need for the home health care revisions

#### **Summary of the Current Draft of the Managed Competition Act of 1992**

The Managed Competition Act of 1992, H.R. 5936 (the "**Act**") would create a Health Plan Purchasing Cooperative ("**HPPC**") in each State (or other defined geographic area). These HPPCs would enter into agreements with accountable health plans ("**AHPs**") In general, all AHPs would be required to offer the same basic benefits (referred to as the "**uniform set of effective benefits**"). Individuals and small businesses would join the HPPC and would be given the opportunity to select an AHP. Large businesses would be permitted to offer to each employee direct enrollment in a qualifying AHP. In order to assist consumers in the selection of an AHP, the AHP would be required to provide the government with price, medical outcome, and other information. An employer's tax deduction would be limited to the lowest priced AHP in the area. The Act would establish the National Health Board (hereinafter referred to as the "**Board**"). The Board would oversee the health market, provide consumers with information about the "quality" of AHPs, adjust for risks of actual enrollment from among AHPs, and recommend the standard benefits package.

In addition, the Act would make additional changes, such as repealing the Medicaid program, providing financial assistance to low-income persons, increasing coverage of preventive health services, reforming malpractice rules, and implementing uniform claim standards

#### ***Purpose of Home Health Care Revisions***

The basic principles underlying these proposed revisions are to ensure access to quality care in all appropriate settings; to encourage appropriate utilization of services, and, moreover, to

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<sup>8</sup> The technical amendments were drafted based on the bill as printed on September 15, 1992. The companion Senate bill is S. 3299



empower consumers with the ability to influence the treatment and setting in which they receive necessary health care services, items, and supplies. Specifically, these revisions are designed to

1. *Empower eligible individuals not only with the freedom to choose the types of treatments that they, and their health care professional, believe would best meet the individuals' needs, but also with the freedom to choose the setting where health care services are delivered; that is, whether the health care services are provided in a health care facility, the patient's home, or other appropriate health care settings.*
2. *Guarantee individuals' freedom of choice in selecting the health care provider with whom they are most comfortable by requiring accountable health plans ("AHPs") to provide eligible individuals with access to care from any health care provider in the service area, even if the health care provider is not under agreement with the AHP.*
3. *Ensure that the uniform set of effective benefits covers a broad array of health care services, even if delivered in the patient's home. These health care services must include, but not be limited, to the appropriate use of physicians, nurses, physical therapists, respiratory therapists, and other health care professionals, items, technologies, equipment, infusion therapy, pharmaceuticals and supplies that are medically necessary to treat or maintain the individuals' medical condition as well as to attain or maintain the individuals' capability for independence and for self-care, including education for either the patients or the patients' caregivers;*
4. *Require the National Health Board to adopt minimum credentialling standards for all health care providers as a minimum indicia to ensure that the quality of health care services provided by the health care provider is adequate. Such credentialling standards could be those established by a recognized accrediting public or private organization, those recognized by the Medicare program under title 18 of the Social Security Act, or those recognized by State law or regulation; and*
5. *Ensure information is provided to individuals and employers that permits them to evaluate AHPs on a comparative basis; that is, provide information that describes not only the types and outcomes of treatment, but also the types of health care providers covered by the AHP as well as the settings in which such covered health care services will be delivered and covered.*

The Managed Competition Act of 1992 would significantly improve access to health care services in the United States. It would provide individuals with a basic set of defined benefits. However, as currently drafted, it may have the unintended effect of limiting the benefits to those which are traditionally included in federal programs. For instance, when the Medicare and Medicaid programs were enacted in 1965, ambulatory and home health care services were only marginally included in these federal benefits packages.

New technologies, coupled with changes in practice patterns and patient acceptance, have increased the number and type of services capable of being provided safely and efficaciously outside of the inpatient hospital setting. Historically, however, the major focus of health care has revolved around hospital inpatient acute care services and physicians' services. The bill must be written in such a way as to keep pace with these technological advances and practice patterns. We must ensure that the limited focus made in 1965 is not repeated twenty-seven years later.

Indeed, a recent report issued by the Office of Technology Assessment entitled *Home Drug Infusion Therapy Under Medicare*, (1992) provides further evidence of Medicare's limited focus. The report stated that Medicare's "benefit structure ... tends to discourage the most independently functional patients from leaving the hospital. To be eligible for home health nursing benefits, for example, beneficiaries must be homebound...." The report goes on to state that the Medicare program's lack of coverage for physician case management services (such as telephone or administrative time) "is a disincentive for physicians to discharge some patients to home care under the current [Medicare program]." It is important that any health care reform legislation

address these barriers to effective health care to reflect the lessons learned from past health care measures

Many private insurers not only have become aware of the cost effectiveness of home health care services, but also have aggressively pursued home care contracts. A 1992 report from InterStudy, for instance, found that "home health care tops the list of cost-control measures used by [health maintenance organizations]."<sup>9</sup>

The technical amendments proposed herein are designed to ensure that the goals of the bill are met. One of the bill's stated goals for reforming the health care marketplace is to "provide access to high quality, cost-effective care through competitive health plans." In order to effectuate this goal, medically appropriate health care services must be available not only in facilities, but also in patients' homes and other appropriate health care settings. We must begin national health reform where the lessons from Medicare and Medicaid leave off.

## **TITLE I. MANAGED COMPETITION IN EMPLOYER-BASED HEALTH PLANS: INCENTIVES TO CONTROL COSTS**

### **SUBTITLE B. HEALTH PLAN PURCHASING COOPERATIVES**

#### ***Summary of Current Draft***

This subtitle would create a Health Plan Purchasing Cooperative ("HPPC") in each State (or other defined geographic area). These HPPCs would enter into agreements with accountable health plans ("AHPs"). Individuals would enroll in an AHP through the HPPC. The HPPC would collect the enrolled individuals' premiums and forward them to the appropriate AHP. The enrollment period, distribution of comparative information, and the period of coverage would be specified. The HPPC would be required to distribute information to eligible individuals and employers. The information would be designed to permit comparison of the various AHPs on the basis of prices, outcomes, enrollees' satisfaction, and other information pertaining to the quality of different AHPs.

#### ***Purpose of Home Health Care Revisions***

The general revisions to this subtitle focus on the types of comparative information provided to eligible individuals and employers regarding different AHPs. In general, it would now specifically require that information provided to individuals, employers, and other interested persons and would include all types of health care providers and health care services each AHP covers as well as the types of settings in which covered services may be rendered. This information would permit eligible individuals and employers to compare more fully the differences between AHPs and, thus, be in a better position to make a more informed decision.

For example, evidence suggests that consumers, where possible, prefer to receive care in their home. However, if AHPs are not required to provide information to consumers on what types of health care providers are covered by the AHP and the settings in which care may be received, consumers would not be able to compare AHPs adequately. Instead of comparing "apples with apples," they will be left comparing "apples with oranges." A better informed consumer would be able to make his or her selection based not only on price but also on other factors that are important to the consumer and consistent with the consumer's lifestyle.

#### ***Technical Amendments***

##### **Section 124(c) Distribution of Comparative Information**

Page 32, line 2 insert after "satisfaction" the following "the types of health care providers and health care professionals covered by the AHP, the settings (health care

<sup>9</sup> InterStudy is an HMO research firm based in Excelsior, MN. Cited in *HomeCare* (Miramar Publishing Company: Culver, CA, November 1992) p. 122.

facilities, patients' homes or other appropriate health care settings) in which the AHP permits the health care services to be rendered"

### SUBTITLE C. ACCOUNTABLE HEALTH PLANS (AHPs)

#### *Summary of Current Draft*

This subtitle would establish the requirements that a health plan would have to meet in order to be registered as an AHP. The AHP would have to (1) offer only the uniform set of effective benefits, (2) enter into agreements with a sufficient number and variety of providers, and (3) have established grievance procedures. It would also preempt certain state laws regarding mandated benefits, restrictions on network plans, and restrictions on utilization review programs. What follows is a discussion of the home health care revisions to each of these sections.

#### Uniform Set of Effective Benefits

##### *Purpose of Home Health Care Revisions*

The bill, as currently drafted, would provide that a health plan may not be accepted as an AHP unless the plan enters into arrangements with a "sufficient number and variety of providers" to provide enrollees the uniform set of effective benefits. However, this section fails to require that the uniform set of effective benefits be available in a variety of settings, such as health care facilities, patients' homes, or other appropriate health care settings. In addition, the term "provider" needs to be broadened to include "suppliers and other health care entities permitted to provide health care services and items." As technology advances and practice patterns progress, many health care services and items can be provided outside of the traditionally defined "provider" setting. Thus, it is important that AHPs be required to enter into a sufficient number of arrangements with all health care professionals and health care providers to ensure that enrollees are provided with sufficient access to necessary health care services provided in any appropriate setting.

##### *Technical Amendments*

*Section 142 Specified uniform set of effect benefits; reduction in cost-sharing for low-income individuals*

#### § 142(a)(2)

Page 39, line 10	delete "providers" and insert the following: "health care professionals and health care providers, as defined in section 191"
Page 39, line 13	insert after "(3)" the following: "in all appropriate setting for the delivery of health care services, including health care facilities, patients' homes, or other appropriate health care setting"
Page 39, line 18	insert before "providers" the following: "health care"
Page 40, line 21	insert before "services" the following: "health care"

#### Collection of Information

##### *Purpose of Home Health Care Revisions*

The bill would require each AHP to provide the National Health Board with specific information. The information, as currently drafted, would include information on characteristics of enrollees that affect their need for or use of health services, information on the types and outcomes of treatment, information on enrollee satisfaction, and information on health care expenditures. This information would be used by the Board to evaluate the AHP's performance. However, the information collected limits the Board's ability to assess fully how effectively AHPs are providing the uniform set of effective benefits. For instance, it does not address

characteristics of enrollees that may affect enrollees' need for health care items, such as equipment and technology. Further, it does not include any information on the setting for the delivery of health care services. In order for the Board to evaluate sufficiently the AHP's ability to provide covered benefits, it must receive comprehensive information on all the health care services that enrollees may use.

### ***Technical Amendments***

#### *Section 143 Collection and provision of standardized information*

This section should be revised as follows:

- Page 41, line 22      § 143(a)(2)(A) --      delete "health services" and insert the following:  
"health care services, including, but not  
limited to health care supplies, health care  
items, and health care technology"
- Page 41, line 24      § 143(a)(2)(B) --      insert after "outcomes of treatments" the following  
"and settings in which treatment is rendered,  
including the patient's home"
- Page 42, line 3 § 143(a)(2)(C) --      insert after "satisfaction" the following "and enrollee  
satisfaction by setting (health care facility,  
patient's home, or other appropriate health  
care setting)"
- Page 42, line 7 § 142(a)(2)(D) --      insert after "procedures" the following "in the aggregate  
and by setting"
- Page 42, line 12      § 142(a)(2)(E) --      delete "providers" and insert the following: "health  
care providers, health care professionals and  
in their selection of the site in which health  
care services are rendered"
- Page 43, line 1/2      § 142(b)(1) -- insert before "provider" the following. "health care"

### **Grievance Procedure**

#### ***Purpose of Home Health Care Revisions***

The bill requires the AHP to have a grievance procedure. However, as currently drafted, this provision does not establish any grievance mechanism between the AHP and health care provider or health care professional. There are several circumstances in which health care providers may have a grievance with the AHP. For instance, the AHP may determine that the health care provider furnished unnecessary services and, therefore, may refuse to reimburse the health care provider for the health care services rendered. Or, a health care provider may have supplied an individual with medical equipment that the AHP later determines was medically unnecessary. Absent a required grievance process, health care providers would be left to settle their disputes in the courts, adding to the already costly litigation process. Thus, it would be prudent to require AHPs to establish a grievance process not only for enrollees but also for health care providers with whom the AHP has entered into an arrangement.

### ***Technical Amendments***

#### *Section 147 Grievance mechanisms; enrollee protections; written policies and procedures respecting advance directives, agent commissions*

- Page 49, line 20      § 147(a) --      insert after "plan" the following "and between the plan and  
health care providers or health care professionals, as  
defined in § 191"



**SUBTITLE D. NATIONAL HEALTH BOARD*****Summary of Current Draft***

This subtitle would create a number of boards. The major board created by this subtitle would be the National Health Board ("**Board**"). The Board would oversee the health market, provide consumers with information on the "quality" of AHPs, adjust for risks of actual enrollment from among AHPs, and recommend the standard benefits package.

In addition, this subtitle would create the Health Benefits and Data Standards Board. The Health Benefits and Data Standards Board would make recommendations to the Board on the uniform set of effective benefits, standards for information collection, and auditing standards. Further, this subtitle would create the Health Plan Standards Board. The Health Plan Standards Board would make recommendations to the Board on standards for AHPs (except for those related to the uniform set of effective benefits and national health data systems) and for HPPCs.

The National Health Board would be given the responsibility to delineate the actual set of effective benefits each year. However, the bill would establish the guidelines that the Board would be required to use in defining the uniform set of effective benefits. What follows is a discussion of the home health care revisions to each of these sections.

**Establishment of National Health Board*****Purpose of Home Health Care Revisions***

The National Health Board would be empowered with the responsibility of specifying the uniform set of effective benefits, determining the standards for qualifying as an AHP, and establishing the process for risk-adjustments of premiums. While the Act requires the President to appoint members that have "experience and knowledge of the health care system," there is no requirement that one of the Board's members be a home health care representative. In order to ensure that health care services rendered in the home are provided, a representative of home health care services (who could either be a consumer or a home health care provider) should be included.

***Technical Amendments******Section 161 Establishment of National Health Board***

Page 61, line 15      § 161(b)(1) -- insert before "." the following: "at least one board member should be a home health care representative"

***Section 163 Health Benefits and Data Standards Board***

Page 67, line 2 § 163(a)(1) -- insert after "system" the following: "including the home care coalition"

Page 67, line 2 § 163(a)(1) -- insert before "." the following: "at least one director should be a home health care representative"

Page 68, line 6 § 163(c)(1)(C) -- insert before "regarding" the following: "and other Federal or Congressional Agencies that may have a comparable need for such information as determined by the Board"

Page 68, line 22      § 163(c)(2)(E) -- delete "and" before "plan"  
insert before "." the following: "and AHP-specific information on the site in which the uniform set of effective benefits are provided and consumer

satisfaction with services by setting, including the patient's home"

#### *Section 164 Health Plan Standards Board*

Page 70, line 5 § 164(b)(1) -- insert before " " the following: "including health care provider networks"

Page 70, line 11 § 164(b)(2) -- insert before " " the following: "including, but not limited to, representatives of the home care coalition"

#### *Section 167 National Health Data System*

Page 74, lines 7/8 § 167(b)(1) -- insert after "procedures" the following: ", in particular, and health care services in general, and the site in which they are provided"

Page 74, line 13 § 167(b)(2) -- insert before " " the following: "and the sites in which the AHPs provide health care services"

Page 76, line 13 § 167(c)(5) -- insert after "information" the following: "and other Federal or Congressional Commissions that have a comparable need for such information as determined by the Board"

### *Uniform Set of Effective Benefits*

#### *Purpose of Home Health Care Revisions*

The bill would require the National Health Board to specify the uniform set of effective benefits. The bill would require the benefits to include "legally authorized treatment for any health condition shown to reasonably improve or significantly ameliorate the condition." As currently drafted, the bill would create a bias against home health care services, including items or supplies often provided. For example, many health care plans provide services, items, and supplies to individuals that are designed to permit them to remain independent or to care for themselves regardless of whether it "reasonably improves or significantly ameliorates a medical condition." Home health care very often serves the ever-growing number of chronically ill people in America.

Consistent with the bill's stated objective of providing access to efficient and effective health care, home health care services should be not only included but also encouraged. Services and items provided to patients in the home are cost-effective, permit patients to continue to live independently, provide the least disruption to the family, and function therapeutically as well. For example, the use of a wheelchair by a quadriplegic provides that person with the opportunity not only to remain in the work setting but also to continue to care for him or herself.

Further, the bill, as currently drafted, fails to address issues related to chronic or terminal illnesses. For example, many health care plans provide health care services that are designed to prevent the rapid deterioration of an individual's medical condition. Many AIDS treatments, for instance, cannot improve or ameliorate AIDS, but they may be effective at slowing the pace in which the patient's condition deteriorates. Thus, the bill should be written in such a way so as not to discriminate against persons with chronic or terminal illnesses.

#### *Technical Amendments*

#### *Section 162 Specification of Uniform Set of Effective Benefits*

This section should be revised as follows:

#### *Section 162(a) Specification of Uniform Set of Effective Benefits*

Page 64, line 5 § 162(a)(2)(A) --	delete "or"	insert after "ameliorate" the following: "or prevent the rapid deterioration of the condition or that allows the enrollee to attain or retain capability for independence or self-care"
Page 64, line 13	§ 162(a)(2)(B) --	insert after "counseling" the following: "and home-based technology"
Page 64, line 14	§ 162(a)(2)(B) --	insert before "specified" the following: "regardless of the setting"
Page 64 line 22	§ 162(a)(2)(C) --	delete "or" insert after "ameliorate" the following: "or prevent the rapid deterioration of the condition or that allows the enrollee to attain or retain capability for independence or self-care"

#### *Section 162(b) Basis for Benefits*

Page 65, line 20	§ 162(b)(1)	insert after "improving" the following: "or maintaining"
Page 65, line 22	§ 162(b)(2)	delete "long-term"

#### *Section 162(c) Basis for Cost-Sharing*

Page 66, line 5 § 162(c)(1)	insert before "," the following: "or inappropriate setting"
Page 66, line 7 § 162(c)(2)	insert before "," the following: "or health care services when rendered in the home"

### SUBTITLE G. DEFINITIONS

#### *Summary of Current Draft*

This subtitle provides numerous definitions. However, several important terms contained in "Title I, Managed Competition in Employer-Based Health Plans: Incentives to Control Costs," are left undefined.

#### *Purpose of Home Health Care Revisions*

These revisions would define several key terms that are used throughout Title 1 to ensure consistency in their application. These terms are health care professional, health care provider, and health care services. For instance, as the bill is currently drafted, the term "provider" often is used to refer only to "institutional settings." However, in today's health care market, many health care entities are able to deliver health care services to patients in a variety of settings. Unfortunately, the bill's current use of the term "provider" continues this bias. Thus, we have revised the term "provider" to be broadened to encompass all health care entities that render health care services, including, but not limited to, hospitals, skilled nursing facilities, home health agencies, home medical equipment suppliers, and home infusion therapy providers.

#### *Technical Amendments*

##### *Section 191. Definitions*

Page 84, line 17      § 191(a) insert the following paragraphs:

- (8) **HEALTH CARE PROFESSIONAL.**-- The term "health care professional" means any individual who provides health care services in a State and who is required by





#### TITLE IV. PREVENTIVE HEALTH AND PERSONAL RESPONSIBILITY

##### SUBTITLE B. EXPANSION OF MEDICARE COVERAGE OF PREVENTIVE SERVICES

###### *Summary of Current Draft*

This section, as currently drafted, would expand Medicare's coverage of certain preventive health services, such as fecal-occult blood tests, screening flexible sigmoidoscopies, and certain immunizations. Further, for Medicare-eligible children, the bill would provide Medicare coverage of well-child care.

###### *Purpose of Home Health Care Revisions*

This section provides coverage of many well-child services. However, coverage is limited to in-office services, such as routine office visits and laboratory tests. Technology advances allow many preventive types of services to be performed at home. This section, therefore, should be drafted to provide coverage of well-child services, items, and supplies, regardless of the setting in which they are provided.

###### *Technical Amendments*

###### *Section 423. Coverage of Well-Child Care*

Page 138, line 18      § 423(b)(2)      insert after "dental care" the following: "and other health care services, (whether provided in a health care facility, a patient's home, or other appropriate health care setting)"

#### TITLE V. MALPRACTICE REFORM

##### SUBTITLE A. FINDINGS; PURPOSE; DEFINITIONS

###### *Summary of Current Draft*

This subtitle would provide states with financial incentives to reform malpractice procedures by encouraging states to develop alternative dispute resolution procedures. This title would limit non-economic damages and would revise the statute of limitations.

###### *Purpose of Home Health Care Revisions*

This section, as currently drafted, would limit the term "provider" only to organizations or institutions licensed or certified by state law or regulation. However, there are many health care entities that are not "directly licensed or certified" by the state, such as certain home health care providers. These entities, nonetheless, are "permitted" to deliver health care services, including items and supplies attendant to those services. Thus, this section should be revised to include all entities that are licensed, authorized, or permitted by the state to deliver health care services and items.

###### *Technical Amendments*

###### *Section 502. Definitions*

Page 144, line 11      § 502(7)      delete "organization" and replace with "entity"

Page 144, line 16      insert before "." the following: "or that is permitted to engage in or provide health care services and items"

## TITLE VI. PAPERWORK REDUCTION AND ADMINISTRATIVE SIMPLIFICATION

### *Summary of Current Draft*

This title would establish national goals to achieve administrative efficiencies by standardizing claims forms and requiring electronic data transmissions. The National Health Board would be given the authority to ensure that these goals are met.

### *Purpose of Home Health Care Revisions*

This title, as currently drafted, limits the term "provider" to "physicians, hospital, pharmacy, laboratory or other persons licensed or authorized" by the state "to furnish health care items or services." There are other health care entities that are not "directly licensed or authorized" by the state, such as home equipment suppliers that, nonetheless, are "permitted" to deliver health care services, including items and supplies attendant to those services. Thus, this section should be revised to include all entities that are licensed, authorized, or permitted by the state to deliver health care services or items. (These are the same definitions recommended for section 191 of the bill.)

### *Technical Amendments*

#### *Section 608. Definitions*

Page 177, line 17      § 608(2)      delete "(2)" and insert the following:

(2) HEALTH CARE PROFESSIONAL.-- The term "health care professional" means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide health care services, any individual who is a qualified graduate from an accredited health care education program, or any individual permitted to provide health care services and receive payment under the Medicare program for those services.

(3) HEALTH CARE PROVIDER.-- The term "health care provider" means any entity or institution that is engaged in the delivery or provision of health care services in a State that is required by State law or regulation to be licensed or certified by the State to provide health care services, that is permitted by the State to provide health care services, that is eligible under the Medicare program to provide health care services and to receive payments under such program, or that is accredited by a public or private voluntary organization approved by the National Health Board.

(4) HEALTH CARE SERVICES.-- The term "health care services" means any service, item, technology, equipment, infusion therapy, pharmaceutical, that is medically necessary to reasonably improve or significantly ameliorate the medical condition or to maintain the individual's medical condition as well as to attain or maintain the individual's capability for independence and for self-care, regardless of where the health care service is provided; that is, whether the health care service is provided in a health care facility, the patient's home, or other appropriate health care settings. The terms "health care services," "health care," and "health care services and items" shall have the same meaning, unless otherwise specified.

\* \* \*

### **FOR MORE INFORMATION CONTACT**

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# STATEMENT OF ALAN K. PARVER, PRESIDENT, THE NATIONAL ALLIANCE FOR INFUSION THERAPY

The National Alliance for Infusion Therapy (NAIT) is pleased to submit comments for the record to the Subcommittee on Health of the Committee on Ways and Means for the April 22, 1993, hearing on basic health benefits. The members of NAIT are national providers of home and alternate-site infusion therapy, as well as national manufacturers of the supplies, drugs and equipment used in the provision of these therapies.

We strongly believe that home and alternate-site infusion therapy should be included as a separate, stand-alone health service in any basic benefit package that is ultimately developed. We take this view because while home infusion therapy has become an integral part of today's health care system, it does not "fit" easily into the conventional notion of home care. It is not standard-issue medical supplies, nor is it simply one of many services routinely performed by skilled nurses. It requires the coordination of nursing, pharmacy, laboratory and ancillary services, along with special medical equipment and supplies, to ensure safe administration of drugs and nutrient solutions. For this reason, home infusion therapy cannot be easily categorized under traditional home care benefits, which usually focus on one component of therapy such as skilled nursing or home medical equipment. We are concerned that if home infusion therapy, for simplification purposes, is classified inappropriately within a standard benefit package, the multidisciplinary nature of the therapies will be lost.

Home infusion therapy essentially offers a "hospital without walls" approach to treatment: Specially trained professionals work as a team to develop a plan of care to provide patients with complex, life-sustaining drug and nutrient therapies in the home. As a result, patients generally recover faster, and the associated costs of therapy are greatly reduced when provided outside the hospital setting. This is especially true in managed care environments, where there is greater emphasis on proper patient selection for home care. For these reasons, infusion therapy has become a fixture of home-based treatment regimens. Medicare covers parenteral and enteral nutrition ("PEN"), and most private payers cover PEN and the other infusion therapies.

It must be noted that these are complex, invasive therapies. They are not optional in any sense of the word. Patients receiving these therapies have a strong, demonstrable need for for such treatments. The primary issue, then, is whether the health reform benefits will permit and encourage the provision of these therapies in the home where appropriate, or whether health reform will turn the clock back and force patients back into hospitals to receive therapy. An important ancillary issue is whether a home care benefit will recognize all that is involved in the provision of therapy. We believe, as noted above, that a separate, discrete home infusion therapy benefit will achieve that important objective.

To amplify our point, let us explain more about the types of therapies delivered in the home and the services necessary for safe provision. Infusion therapy generally involves the administration of drugs, solutions and nutrients parenterally (outside the digestive tract) or enterally (directly into the digestive tract). The types of infusion therapy most commonly provided in the home include antibiotic therapy, chemotherapy, pain management, parenteral nutrition and enteral nutrition.

Antibiotic therapy is used to treat a variety of infections such as osteomyelitis, cellulitis, endocarditis, respiratory, urinary tract, gynecologic, post-operative infection, cytomegalovirus infection, cystic fibrosis, chorioretinitis, pneumonia and Lyme disease. Patients who are HIV-positive rely on intravenous antibiotic therapy to combat opportunistic infections. Antibiotic therapy is commonly delivered through an intravenous catheter placed in the arm.



Chemotherapy is intended to destroy or alter the growth pattern of malignant cancer cells for cancers such as bronchial/lung, breast, prostate, colon, recto-sigmoid, kidney, ovarian and multiple myeloma. Because the potential dangers of intravenous chemotherapy include life-threatening toxicity, physicians, nurses and pharmacists must monitor chemotherapy patients closely.

Pain management using narcotics can alleviate severe pain, thereby decreasing anxiety and enhancing the quality of the patient's life. Chronic and severe pain may be caused by cancer, neurologic, orthopedic or certain AIDS-related conditions. Home pain management enables patients to leave the hospital and receive therapy in the comfort of their homes. It also enables terminally ill patients to spend the last weeks of their life in relative comfort in familiar surroundings with family and loved ones. Pain management is often administered through a catheter placed in the epidural space around the spinal cord.

Also referred to as total parenteral nutrition (TPN), parenteral nutrition enables patients to meet their daily needs for carbohydrates, proteins, vitamins, minerals, trace elements, fats and other nutrients through a surgically inserted venous catheter or other vascular access device. Parenteral nutrition is often recommended for patients with malnutrition resulting from Crohn's disease, short-bowel syndrome, bowel obstruction, severe burns, malabsorption syndrome, pancreatitis, cancer, ulcerative colitis and AIDS-related malnutrition. The common element of these indications is that the patient's digestive system does not permit the patient to absorb nutrients sufficient to maintain adequate weight and strength. Parenteral nutrition is often administered through a central catheter placed in the large vein over the heart.

Enteral nutrition involves tube feeding directly into the patient's stomach or intestine. Enteral nutrition therapy is appropriate for patients whose lower gastrointestinal tract functions normally but who are unable or unwilling to swallow, who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth. Likely causes include recent surgery of the gastrointestinal tract, mechanical obstruction or malfunction caused by a malignant or non-malignant disease, a comatose state or Alzheimer's disease. Most enteral nutrition patients are fed through a tube is inserted by a physician or nurse through the nasal passage with the proximal end placed into the patient's stomach or duodenum. Less frequently, enteral nutrition patients are fed through gastrostomy or jejunostomy tubes, which are inserted through a surgical incision in the abdominal wall, with the proximal end placed directly into the duodenum or jejunum.

The safety and efficacy of the therapies just described cannot be ensured without proper oversight from the infusion therapy provider. All professionals involved in the patient's care, including the physician, nurse, pharmacist, dietician and social worker, if necessary, must collaborate to provide a program of services tailored to the patient's needs.

Infusion therapy patients must be carefully screened to determine suitability for home therapy. The provider assesses the patient's clinical condition and social readiness for home therapy and develops a plan of care based on the physician's orders. The patient and care partner receive education and training on the goals and objectives of treatment, the principles of the therapy prescribed, aseptic technique, preparation of the drug and delivery system, operation of the equipment, care of the vascular access device, emergency procedures and a variety of self-monitoring skills. The first dose of the drug or nutrient is usually administered in the hospital and always under close supervision.



Home infusion therapy nurses must possess the training and experience needed to render a variety of routine and complex infusion-related skilled services, ranging from the insertion of intravenous catheters and nasogastric enteral feeding tubes to the assessment of the patient's home environment. The nurse must also be knowledgeable about and capable of operating sophisticated pumps and other specialized equipment.

In the home, nurses provide one or more of the following services:

- Evaluate the patient's response to therapy;
- Evaluate the catheter site for infection and other catheter-related complications;
- Assess other clinical aspects of the patient's therapy or condition;
- Change catheter dressings;
- Rotate catheter sites;
- Administer drugs;
- Obtain blood or other specimens for laboratory analysis;
- Assess the patient's home environment and support systems;
- Evaluate whether medical equipment is operating properly and being used correctly;
- Provide additional training for the patient and/or care partner, answer questions, and provide emotional support;
- Begin to document clinical observations and make recommendations for the ongoing plan of care.

At the outset of therapy, the home infusion therapy pharmacist conducts an initial patient evaluation based on the clinical information obtained from the nurse's assessment, communications with the physician and patient, the physician's orders, analysis of laboratory test results and other pertinent clinical information. As therapy proceeds, the pharmacist's findings and recommendations are communicated at intervals to the physician, nurse and other professionals involved in the care of the patient.

Infusion pharmacists prepare drugs and nutrient solutions under environmentally controlled conditions as mandated by various regulatory and accreditation agencies. Sterile admixtures are prepared in a "Class 100" clean air environment, using aseptic techniques. Each patient's prescription is filled in quantities and at intervals sufficient for continuous service.

Throughout the course of therapy and particularly after a nursing visit, the pharmacist reviews clinical information collected by the nurse, discusses the findings with the attending physician, assesses the continuing appropriateness of the current medication schedule, participates in patient care conferences to examine the patient's progress and to establish future goals, and communicates with the patient's other caregivers regarding the patient's compliance and progress.

The successful provision of home infusion therapy depends on a variety of services in addition to direct patient care. These include discharge planning, administrative and support services and quality assurance and improvement programs.

Clearly, home infusion therapy is a fairly complex undertaking. All participants in the system, from the physician to the delivery personnel, must work together to ensure smooth coordination of services. The success of home infusion therapy over the last decade is largely attributable to the ability of providers to maintain this kind of coordination in a cost-effective manner. This fact should not be overlooked as policymakers attempt to structure a basic health benefits package. We believe that if home infusion therapy is wrapped

into a general home care benefit, or defined as simply nursing or equipment, there is risk of compromising efficacy of therapy and patient safety. For that reason, we suggest that home and alternate-site infusion therapy be included in basic benefit packages as a separate, stand-alone health service.

If the Subcommittee has any questions, please contact either Alan K. Parver or Jana D. Sansbury at (202) 347-0066.

## Statement for the Hearing Record

Lawrence A. McAndrews, President & CEO  
 National Association of Children's Hospitals  
 and Related Institutions  
 (703)684-1355

Mr. Chairman, on behalf of NACHRI -- the National Association of Children's Hospitals and Related Institutions -- I am pleased to submit this statement for the record of the Subcommittee on Health's March 30, 1993, and April 22, 1993, hearings on "Health Care Reform: Consideration of Benefits for Inclusion in a Standard Benefit Package."

Background

NACHRI is the only national, voluntary association of children's hospitals in the United States. It represents more than 100 institutions in the United States, including free-standing acute care children's hospitals, pediatric departments of major medical centers, and specialty children's hospitals, such as pediatric rehabilitation and chronic care facilities.

Virtually all of the children's hospitals are teaching hospitals and research centers, and many function as regional referral centers for specialized care. On average, a free-standing, acute care children's hospital devotes nearly half of its care to children who depend on Medicaid or are uninsured, and more than 65 percent of its care to children with chronic and congenital conditions. The children's hospitals represent only one percent of all hospitals in the country, but they care for 12 percent of all hospitalized children and 24% of all hospitalized children with chronic and congenital conditions. They also train approximately one quarter of all pediatricians and are regional pediatric referral centers for services such as pediatric trauma care, intensive care, and transplantation.

While they are best known as tertiary level hospitals providing highly specialized inpatient care for very sick, disabled, or injured children, children's hospitals also are major providers of outpatient care, including primary and specialty care. Children's hospitals deliver extensive outpatient care. On average, a children's hospital provides care in more than 89,000 visits by patients to ambulatory clinics annually. (These visits involve primary or specialty care they do not include emergency room or surgical visits.)

As a consequence of the breadth of their experience in the delivery of preventive and primary care, acute and subspecialty care, rehabilitative and long term care to children, NACHRI member hospitals recognize and understand the distinct health care needs of children. Compared to adults, children require more primary and preventive health care. But when they are hospitalized, they often require more intensive inpatient care. And children with chronic and congenital conditions also have distinct needs for habilitative, rehabilitative, and long term care.

NACHRI's recommendations for a standard benefits package for children are based on its member hospitals' understanding of the full range of children's health care needs. In particular, our statement speaks to three sets of issues:

- **general principles** that should guide the development of uniform benefits for children;
- **specific benefits** that should be encompassed in a uniform benefits package;
- **benefit limitations in standard HMO coverage** that will deny essential care to children with chronic and congenital conditions.

General Principles

Business, child health, and education groups -- including NACHRI -- have joined together in the Children First Coalition to recommend

to the President's Task Force on National Health Care Reform four general principles that should guide the development of a uniform benefit package for children as a part of comprehensive health care reform:

- If comprehensive reform is achieved through a phased-in approach, coverage for children and pregnant women should be phased in first.
- A national, uniform benefits package should recognize and address the unique needs of all children, covering all medically necessary and appropriate services, with an emphasis on primary and preventive services.
- A broad representation of child health experts should be involved in determining what services are medically necessary and appropriate for children, with such determinations based on current and developing knowledge of health outcomes.
- Comprehensive health care benefits and the full continuum of care for children should be delivered through organized systems of care with appropriate pediatric providers, recognizing that these systems are currently developing in the integration of the delivery and financing of care.

There is in Title XIX of the Social Security Act an important federal precedent for applying these principles to the development of a comprehensive, uniform health benefits package for children. As amended by Congress in 1989, the federal Medicaid EPSDT program -- Early and Periodic Screening, Diagnosis and Treatment -- guarantees to children medically necessary care identified in either a regularly scheduled or an interperiodic EPSDT screen. The federal EPSDT definition of health coverage for children does the following:

- EPSDT guarantees broader coverage for children than for adults under Medicaid. A child diagnosed to require medically necessary care is entitled to all Medicaid benefits -- both mandatory and optional -- regardless of whether a state otherwise covers any of the federally recognized optional Medicaid benefits. In effect, Medicaid guarantees comprehensive coverage first for children.
- EPSDT guarantees medically necessary care to children, to be determined in the context of regularly scheduled or interperiodic health care screens designed to ensure that children receive appropriate primary and preventive health care, in addition to identifying the need for all medically necessary care. In effect, Medicaid establishes a national uniform benefit package for children, guaranteeing medically necessary and appropriate care, with an emphasis on primary and preventive care.
- EPSDT guarantees medically necessary care only when it is identified by an appropriate health care provider in the context of an EPSDT screen. In effect, Medicaid requires a determination of medical necessity by an appropriate child health care provider according to specific screening standards.
- EPSDT encourages coordination of care, with an emphasis on primary and preventive care -- the same emphasis on cost effective care which is the goal of the best organized systems of care delivery. In effect, Medicaid's EPSDT program is intended to foster care coordination just as organized and integrated care delivery systems are intended to accomplish such coordination.



### Specific Benefits

In the context of these broad principles to define comprehensive health care benefits for children, NACHRI has joined the American Academy of Pediatrics in recommending to the President's Task Force on National Health Care Reform a distinct package of benefits for children, which emphasizes primary and preventive care while meeting children's full needs for medically necessary and appropriate care. They include:

- **child preventive care**, including routine office visits, routine immunizations, routine laboratory tests, and preventive dental care;
- **prenatal care**, including care of all complications and family planning;
- **care of newborn infants**, including attendance at high-risk deliveries and normal newborn inpatient care;
- **child abuse assessment**;
- **hospital services**, including all inpatient care for acute and chronic conditions, emergency room care, hospital or health facility transport, treatment for injury to normal gums and teeth, acute home health care, surgery and anesthesia services, therapeutic radiology services, and nursing care;
- **physician services**, including inpatient and outpatient physician care for acute and chronic conditions, subspecialty consultations and treatment, diagnostic services (diagnostic radiology services, laboratory tests, and diagnosis of developmental and learning disorders), acute dental care, medical and surgical supplies, corrective eyeglasses or lenses, hearing aids, medical equipment, and prescription drugs, including nutritional supplements; and
- **extended major medical services**, including care coordination for chronically ill and other "at-risk" children, orthodontia (other than cosmetic), treatment of developmental and learning disabilities, mental health services, substance abuse services, speech therapy, occupational therapy, physical therapy, hospice care, respite care, recuperative stays in long-term care facilities, and nutritional assessment and counseling.

We believe the delivery of these benefits should occur in the context of care coordination by primary care physicians, preferably pediatricians, including pediatric subspecialists where appropriate for children with special health care needs. We also believe that cost-sharing requirements should encourage primary and preventive care while not discouraging medically necessary care.

### Benefit Limitations in HMO Coverage

According to its staff, the President's Task Force is focusing its consideration of a comprehensive health benefits package on a standard HMO benefit package, such as is provided under the Kaiser Federal Employee Health Benefit Plan.

Based on the children's hospitals' experience in caring for children with chronic and congenital conditions such as cerebral palsy, cystic fibrosis, or spina bifida, the most striking inadequacy of the Kaiser plan for federal employees is its two month limit per condition for rehabilitative therapies, including physical and occupational therapy, on both an inpatient and an outpatient basis. Such a limit permits coverage of these services only during the first two months following diagnosis of the condition requiring therapy. A two-month per condition limit would

effectively deny essential care to children with life-long chronic and congenital conditions, despite the fact that such therapies, if appropriately provided, reduce hospital stays and enhance the potential for independent living.

Consider the following examples:

- **Scoliosis** A child with scoliosis or curvature of the spine usually requires a course of treatment including braces with physical therapy to avoid the necessity of surgery. The course of treatment generally calls for approximately 15 physical therapy visits over a period of three years. These visits would not be covered beyond the first one or two under a two month per condition limit.
- **Cerebral Palsy** For the child with cerebral palsy, physical therapy is essential both to achieve and to maintain mobility and function. It promotes optimal independence and can reduce the necessity of orthopedic surgery. Physical therapists normally establish a program of exercise and stretching with the family, who then follows through with ongoing therapy at home. If surgery is required, physical therapy is essential follow-up to ensure a successful outcome. If the child with cerebral palsy has any acute injury or illness, physical therapy may be required. None of these therapies constitute long-term care, but all can be life-long for a child with cerebral palsy, which is a life-time condition.
- **Cystic Fibrosis** Cystic fibrosis also is a life-time condition, with physical therapy including postural drainage and respiratory treatment. Physical therapists work with parents who perform the routine treatments. But the physical therapists' treatment are not concluded in one two-month period.
- **Congenital Amputee** As they grow, children with amputations -- whether due to injury or cancer treatment -- will require multiple prostheses over time, requiring both physical and occupational therapy. Such therapy would exceed a two month limit.

In each instance, the appropriate therapies, when medically prescribed, are in the best interests of both the health and well-being of the child and the delivery of the most cost-effective care. A definition of comprehensive health benefits for children should replace a two-month limit per condition with either a two month limit per inpatient stay and 12 month limit on an outpatient basis per episode of illness, or the equivalent number of visits necessary to maximize a child's opportunity for restoration of normal age-appropriate functioning.

Essential to the appropriate use of physical, occupational, and other therapies for children with chronic and congenital conditions is the provision of case management and regular assessments for such children by experienced providers.

### Conclusion

NACHRI strongly recommends that the design of a uniform benefits package for children -- whether based on a standard HMO benefit package or any other set of benefits -- should reflect both the general principles we have advocated and include the specific services listed in this statement. The children's hospitals would be pleased to be of assistance in attempting to answer any questions the Subcommittee and its members may have.

## **STATEMENT OF MARGARET GREY, PRESIDENT, NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS**

On behalf of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP), I appreciate this opportunity to provide a written statement for the record. My name is Margaret Grey, DrPH, FAAN, CRNP and I currently serve as the President of NAPNAP. NAPNAP represents approximately 4,000 Pediatric Nurse Practitioners (PNPs) who specialize as pediatric, family or school health practitioners. Our organization was founded in 1973 to meet the professional and educational needs of our growing specialty, to maintain the quality standard established for Pediatric Nurse Practitioners (PNPs) and to promote quality health care for consumers.

The purpose of our statement is to provide the Subcommittee on Health of the House Committee on Ways and Means with a list of standard or uniform health benefits that PNPs feel are essential in addressing the needs of our nation's children. NAPNAP strives to enhance the quality of health for infants, children and adolescents. Any new health care system must recognize children as our nation's most valuable resource. NAPNAP believes all children deserve access to health care regardless of race, economic status or religious beliefs. NAPNAP is concerned that many children do not have insurance and/or access to necessary health care services.

Preventive services should be at the core of any health benefits package. NAPNAP believes that the health care system should incorporate changes which focus on the promotion of health and the prevention of disease. In general, the current health care system places too much of an emphasis on the treatment of disease rather than on the prevention of disease. Preventive health care includes those activities which actively promote responsible behavior and the adoption of healthy lifestyles. Prevention is the best opportunity to reduce the increasing portion of economic resources that are spent to treat preventable illness and functional impairments. The promotion of health through behavior will keep American children healthier and enable financial and social resources to be used more wisely.

NAPNAP has identified a number of health care services that both children and young adults should receive under a new health benefits package including:

- **Prenatal Care**, including routine office visits at recommended intervals; additional care and guidance when necessary for the pregnant adolescent; nutritional counseling; childbirth education and lactation consultation; and genetic counseling as appropriate
- **Well Child Care**, including routine office visits at recommended intervals for all children birth through 21 years; individualized and anticipatory guidance related to expected health and development; promotion of breast feeding for infants; routine immunizations; growth and development assessments; periodic screening and evaluation of hearing, vision, and speech development; routine laboratory screening for elevated cholesterol and lead levels as well as periodic screening for abnormal blood and urine findings; periodic tuberculosis screening; other diagnostic screening services related to health and development as needed; and promotion of reproductive health and family planning
- **Rehabilitation Services**, including physical therapy, occupational and speech therapy
- **Prescription Medications**
- **Dental Care**
- **Vision Care**
- **Mental Health Services**, including evaluation of children and families; counseling for children and families; and social services as necessary
- **Health Education/Teaching**, including parenting skills; growth and development concerns; nutritional needs and dietary modifications as needed; lifestyles and habits counseling to encourage maximal health potential and for chronic disease and/or handicap conditions such as asthma or diabetes; prevention of child abuse and other forms of violence; and injury prevention

NAPNAP believes that primary care must be incorporated as a basic construct into the health care benefits package and made available to all children and families. Primary health care services are a way of ensuring a comprehensive array of support services across the health care spectrum regardless of the delivery site. A primary health care system allows clients to become more informed about their health care and provides for increased participation and better health care management. Furthermore, a primary health care system increases the proportion of people who receive complete sets of essential preventive services at recommended intervals, thereby emphasizing the importance of a coordinated and holistic approach to preventive and primary care.

Nurse practitioners (NPs) are primary health care providers. Primary health care providers are necessary partners in the maintenance of good health and treatment of minor acute and chronic illness, and the management of stable chronic health conditions. In drafting and debating any new health care reform proposal, we urge both Congress and the President to recognize nurse practitioners as primary care providers. Specifically, we hope that all insurance plans offer the consumer the choice of receiving care from a nurse practitioner as long as the nurse practitioner is practicing in accordance with state law or state regulations.

Furthermore, NAPNAP believes a minimum benefits package should be determined by Congress rather than a national health board. The process would then remain open to the public and Members of Congress would be held accountable for their decisions to their constituents. NAPNAP is concerned that a national health board may not equally represent the interests of all health care providers. The decisions and outcomes of such a board may therefore be biased.

This written statement outlines what NAPNAP considers to be the "bottom line" elements of a health benefit package which must be incorporated into any health care reform proposal. We feel preventive and primary care services must form the core of any benefit structure. More importantly, we believe that Congress should define the standard health benefits package and not a Board. NAPNAP's commitment to focusing on the optimal physical, mental, emotional, and social health of the nation's children encourages them to grow and develop to their fullest potential.



STATEMENT OF  
THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC

HEARINGS ON A STANDARD BENEFITS PACKAGE AND  
HEALTH CARE REFORM

MARCH 30 AND APRIL 22, 1993

Mr. Chairman:

This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF). NARF is a national association representing over 900 medical, vocational, and residential facilities. The majority of our members participate in the Medicare and Medicaid programs. Our facilities serve over 3.7 million people annually.

You and your committee have a great responsibility and opportunity in reinventing health care for America.

**I. WHAT IS REHABILITATION?**

Rehabilitation refers to a variety of services provided to people who have experienced a severe injury, illness, have a congenital abnormality or developmental disability. The goal of such services is to minimize physical and cognitive impairments, restore functional ability and return people to work, to home, and to school.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a complete team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts.

Each patient is individually evaluated prior to admission to a rehabilitation facility, and/or directly after admission, to determine his or her functional level, medical status and needs. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person had a stroke which impaired the ability to walk, see, swallow and which created weakness on the left side. The goals would include walking again independently, swallowing without aid, seeing well enough to read and ideally drive, strengthening the left side so the arm and leg can be used, and being able to dress independently again. If someone had a leg amputated due to diabetes or traumatic injury, the goals would be complete, proper healing of the stump, preparation for fitting with a protheses, use of the protheses, walking first with an aid such as crutches or a cane and then independently without an aid. All of this is very hard work for the person, the therapists and nurses.

Over four million people receive rehabilitation services annually. Over 80% return to their homes, work, schools or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, cancer, burns, multiple trauma, and congenital or developmental disorders.

**II. WHERE IS IT DELIVERED?**

Rehabilitation is delivered in a number of places - freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, nursing facilities and in people's homes. Which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

### III. HOW IS REHABILITATION CURRENTLY COVERED?

#### *Coverage of Rehabilitation Services is Standard in Today's Insurance System*

Rehabilitation services are a standard benefit in most health insurance packages currently offered by both public and private payers. Americans have come to expect that the range of therapies needed to improve their functional capacity and autonomy will be provided. Notwithstanding the wide diversity of health care payers in the U.S., virtually all of them cover rehabilitation therapy in one form or another. This is true in both the public and private sectors.

- **Medicare** -- The federal Medicare program covers occupational and physical therapy, speech-language pathology and audiology, respiratory therapy, social work services, rehabilitation nursing and psychology in a range of inpatient and outpatient settings. The program also provides coverage of items that are frequently essential to rehabilitation care including orthotics (braces and splints), prosthetics (limbs), and durable medical equipment. Providers recognized under Medicare include rehabilitation hospitals, rehabilitation units in general hospitals, rehabilitation agencies, clinics, nursing facilities, CORFs, and home health agencies.
- **Medicaid** -- Rehabilitation services also are covered within the Medicaid program. Every state Medicaid plan covers rehabilitation services when provided within a hospital (both inpatient and outpatient), nursing facility, home care, or under the Early and Periodic Screening, Detection and Treatment (EPSDT) program, since coverage of each of these benefits is mandatory under federal law. With respect to optional Medicaid benefits, rehabilitation services may be covered when provided by clinics, rehabilitation agencies, CORFs, and independent practitioners. Most states have chosen to furnish rehabilitation services in these optional settings. However as many states face severe budget problems, we find that the availability of these services or simply any payment (whether mandatory or not) for them is being cut back.
- **Black Lung** -- The Black Lung Program, which provides federal assistance to coal miners and their dependents, has covered and reimbursed outpatient pulmonary rehabilitation since 1978.
- **State Mandatory Coverage Laws** -- Several states have enacted legislation mandating coverage for specific rehabilitative services. For example, Delaware and Louisiana have recently passed laws requiring coverage of physical therapy, speech-language pathology and audiology services, and occupational therapy. Rehabilitation services are mandatory in one form or another in Connecticut, Maine, Massachusetts, West Virginia, Missouri, Texas, Tennessee and Arkansas.
- **Private Insurance** -- The private health insurance industry also routinely offers coverage of rehabilitation services. While insurers may limit the number of rehabilitation visits covered or apply an annual monetary cap, very few limit coverage by specific diagnosis or clinical indication. Most plans require that rehabilitation services be ordered by a physician and furnished by providers having specific credentials. For example, many plans will cover physical therapy only if provided by a licensed physical therapist.
- **Blue Cross/Blue Shield Plans** -- Based on an informal national survey, it is clear that respiratory therapy, speech-language pathology services, audiology, and physical and occupational therapy services are commonly covered by the Blue Cross/Blue Shield plans in the country. In particular, while the scope of coverage varies by plan and insurance product, physical and occupational therapy are routinely covered, and speech-language pathology services and respiratory therapy are usually covered subject to certain limitations (e.g., limited diagnoses, duration, and/or settings).
- **HMOs** -- Rehabilitation therapy is also covered somewhat in the HMO market. The 1992 HMO Industry Survey conducted by the Group Health Association of America included questions on rehabilitation coverage for the first time. The results showed that most HMOs, regardless of their federal qualification status, cover some rehabilitation services.

We would like to note however, that while individual services have been covered, there have been some problems with the delivery of rehabilitation services by existing managed care plans. The regulations implementing the HMO Act require federally qualified HMOs to offer services as follows:

"(a) An HMO shall provide or arrange for the provision of basic health services to its members as needed and without limitations as to time and cost other than those prescribed in the Public Health Service Act and these regulations, as follows:

(iii) Outpatient services and inpatient hospital services shall include short term rehabilitation services and physical therapy, the provision of which the HMO determines can be expected to result in the significant improvement of a member's condition within a period of two months." 42 CFR 1701.101

The major problem is in the interpretation of this regulation. Nonqualified HMOs set their own limits. Many plans interpret one therapy visit as a day of service, which eventually exhausts the benefit prior to the patient receiving the comprehensive rehabilitation services needed for a complete recovery. For example in California two men had a similar spinal cord injury. After five months in therapy, one man recovered and is back at work and with his wife and family. The other man abruptly left rehabilitation. The first man found out that his colleague left rehab not for any medical reason, but because his HMO would only cover 60 days of care. According to the first man, it sent the second man to a rest home where he received no therapies, was in bed and turned once a day. All the gains he made in rehabilitation were lost and he was totally dependent.

Some HMOs do not refer to a comprehensive acute rehabilitation program as a matter of practice, even though the patient may readily meet the admission criteria. We have also recently heard that a large risk based HMO will not refer stroke patients to acute rehabilitation but instead is sending them to a nursing facility without the benefit of intensive rehabilitation therapy. This rule of thumb may not be appropriate for all stroke patients.

#### IV. COST EFFECTIVENESS OF REHABILITATION SERVICES

Expenditures made for rehabilitation services are investments in human capital. Rehabilitation improves functional problems and reduces the cost of care. This has been verified in a number of studies and surveys conducted by the insurance industry. For example, a survey conducted by the Health Insurance Association of America (HIAA) of member companies reported a savings of \$11 for every \$1 spent on rehabilitation, with "a savings per claimant ranging from \$1,500 to over \$250,000." A Northwestern National Life Insurance study shows a savings of \$30 for every \$1 spent. Other studies have confirmed that early rehabilitation for stroke and traumatic brain injury lead to shorter overall hospitalization, less mortality and fewer complications; that comprehensive rehabilitation programs are effective in treating low back pain; and that pulmonary rehabilitation reduces expensive rehospitalization and emergency room visits.

Rehabilitation services are viewed as cost-effective for the following reasons:

**Rehabilitation services return patients to productive lives** -- rehabilitation is widely acknowledged as one of the most effective forms of prevention for survivors of serious illness, disease and injury. Through rigorous physical, social and cognitive restoration programs, rehabilitation prevents these survivors from becoming persons with permanent or long-term disabilities. It assures that any residual impairment does not become a disability affecting an individual's activities at work, home, school, play or ability to enjoy an active retirement.

**Rehabilitation prevents complications** -- Rehabilitation is also well known for its efficacy in preventing complications and subsequent re-hospitalization, which can be very costly. For example, rehabilitation helps prevent deep vein thrombosis, cardiac involvement, pressure ulcers, contractures, pulmonary emboli, and emotional dependence and depression.

**Rehabilitation speeds recovery** -- Several studies have shown that stroke patients who receive rehabilitation have better outcomes than those who do not. Additionally, these studies indicate that stroke rehabilitation patients are more likely to be discharged to home than to long term institutionalized care. They are also likely to live longer and are more likely to retain a higher level of function and activity. A 1981 study found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus a long term residential institutional setting saved \$13,248 per year, in 1981 dollars, or \$20,447.61 in 1992 dollars per year. Given that the average stroke patient lives over 5 years, this is a savings of \$102,238.12 in 1992 dollars.

**Rehabilitation maximizes the restoration of functional capacity** -- Rehabilitation can help consumers adapt to a physical challenge and lead a more independent life. To understand the impact of rehabilitation, it can be helpful to consider a daily example: an individual's ability to dress independently. Many older spouses and family members do not have the physical strength required to assist a loved one in this daily routine. The consequences of employing a



nurse or aide, if available at all, to assist in this daily process can be costly and discouraging. In a study of 329 rehabilitation patients, 245 required total or maximum assistance to dress on admission. At discharge, 156 required only a minimal level of assistance. If we assume that helping someone dress requires half an hour a day, then the improvement of 156 patients to require only a minimal level of assistance (which could be provided by a spouse or family member) would save 28,470 hours per year. If a minimum wage of \$4.25 applied to each individual needed to help a person dress, an annual savings of \$120,997 could be realized. This does not acknowledge travel time either. Similar logic can be applied to the savings that result from a rehabilitation patient's attaining independence in other areas of daily life. These include independent locomotion and the management of bladder skills, which can reduce the risk of infection and the need for further medical intervention.

**Preventive rehabilitation improves workplace productivity** -- The benefits of rehabilitation do not begin only with the occurrence of an injury, rather they start with injury prevention in the workplace. Through workplace prevention, rehabilitation saves countless health care dollars as well as lost hours of productivity. Some rehabilitation professionals specialize in working with employers to examine work sites, identify hazards and eliminate the potential for work-related injuries. The Public Health Service estimates that in 1989 there were 192 cases of cumulative traumatic disorder (just one kind of work-related injury) per 100,000 workers. These disorders affected workers who engaged in repeated wrist-twisting motions, from computer users to meat cutters to grocery store check-out clerks. The proactive involvement of rehabilitation professionals in the workplace can help reduce the incidence of these cumulative traumatic disorders through the modification of work stations, the analysis and improvement of the motions used in work (particularly in repetitive working situations) and by coaching good lifting techniques. These precautions help prevent workplace injuries and the need for more major medical intervention. These savings are particularly important since workers comp costs are increasing at a rate of over 20% a year, and creating a tremendous burden for many businesses.

#### V. CONCLUSION AND RECOMMENDATIONS

It is good policy and good health care to continue to include and recognize rehabilitation in tomorrow's standard benefit package.

- \* Rehabilitation services improve people's lives and productivity.
- \* Rehabilitation services are cost effective.
- \* Rehabilitation outcomes can be measured.

Our recommendations are:

- A. That a standard benefits package must continue to include the full range of rehabilitation services (including restorative and preventive services) to help people improve functioning and lead productive lives. The range of benefits covered by most major commercial insurance policies and Medicare represent good starting points. A list of citations to coverage of rehabilitation services under Medicare is attached.
- B. That rehabilitation services should be covered in every setting deemed appropriate based on the person's functional status. Services must be available in a continuum of inpatient and outpatient settings, including community based facilities and at patients' homes.
- C. That Congress retain the authority to establish a benefits package.
- D. That the benefit package be able to evolve to respond to new, cost effective prevention and treatment approaches.



## REHABILITATION SERVICES COVERED UNDER THE MEDICARE PROGRAM

Hospital Services.

Section 1861(e)(1)(B) of the Medicare Act includes in the definition of the term "hospital" an institution providing "rehabilitation services for the rehabilitation of injured, disabled and sick patients."

Thus, rehabilitation facilities, which meet the generic definition of a hospital, are treated as such by the Medicare program.

The principal problem in this area is not coverage, but Medicare payment policy, whereby hospitals are paid widely varying rates for essentially the same services.

There are about 155 freestanding rehabilitation hospitals recognized by the Medicare program and excluded from the PPS.

Skilled Nursing Services.

Similarly, section 1819(a)(1)(B) includes in the definition of a "skilled nursing facility" an institution which is engaged in the provision of "rehabilitation services for the rehabilitation of injured, disabled, or sick persons."

The distinction between these types of facilities is the degree of nursing intensity, physician supervision and levels of therapies.

Rehabilitation Units.

Services in rehabilitation units in general hospitals are covered under the general heading of "hospital services." They are, like rehabilitation hospitals, excluded from the Medicare PPS and Medicare reimburses for services in such units under the same payment system used for rehabilitation hospitals, with the same inequities.

There are about 700 such units recognized by the Medicare program.

Outpatient Services.

Services to outpatients by rehabilitation hospitals and other providers are covered under section 1861(s), "Medical and Other Health Services."

Comprehensive Outpatient Rehabilitation Facility Services.

The services of comprehensive outpatient rehabilitation facilities

are covered under Part B. These include all of the services covered in a hospital, except room and board. The definitions controlling such facilities and their services are contained in section 1861(cc). All Part B services are incorporated in 1861(s).

There are about 200 such entities recognized by the Medicare program.

#### Home Health Services.

Home health services, as defined in 1861(m), include several services that are common elements of a rehabilitation program, such as physical, occupational and speech therapies.

#### Outpatient Physical Therapy Services. Speech Pathology Services. Rehabilitation Agencies and Clinics.

These are covered under 1861(s) and defined by 1861(p).

#### Outpatient Occupational Therapy Services.

These are covered under 1861(s) and defined in 1861(g).

These are the principal elements of the Medicare Act which provide for coverage of rehabilitation services. They have evolved over the existence of the program to be fairly comprehensive and are regarded as generally appropriate by the rehabilitation field. There are, as indicated, problems with payment policy and some other matters that could improve the rehabilitation benefit, but overall the Medicare Act is a good starting point for appropriate coverage of such services.

NARF

Statement of Louis Núñez, President,  
National Puerto Rican Coalition

House Ways and Means Committee  
Subcommittee on Health  
Hearings on Health Care Reform:  
Consideration of Benefits for Inclusion in a  
Standard Health Benefit Package

April 13, 1993

Mr. Chairman, and members of the subcommittee, my name is Louis Núñez, and I am President of the National Puerto Rican Coalition. The National Puerto Rican Coalition is a membership association which represents over one hundred Puerto Rican community-based organizations as well as hundreds of concerned individuals. NPRC's goal is to further the social, economic, and political well-being of nearly six million American citizens of Puerto Rican descent throughout the United States and Puerto Rico. I wish to thank you for this opportunity to provide you with the National Puerto Rican Coalition's view of the health care needs of the Puerto Rican community and recommendations for a health benefit package which will meet those needs.

### The Problem

The single greatest health care challenge facing the Puerto Rican community in America is "reasonable" access to health care services. Despite a number of past and current programs by federal and state government and industry, there is a growing cohort of Puerto Ricans who lack any access to many basic health care and human services. This is manifested, in part, by "excess" morbidity and mortality for many diseases, and the sad fact that often times the hospital ward is the environment in which Puerto Ricans experience the United States' health care delivery system.

The recent outbreak of measles epidemics, a preventable disease, including deaths in Puerto Rican communities, represents a very serious problem. We have a startling juxtaposition of expensive high tech medical services for many in America, while "basic" preventive immunizations are unavailable for others. While this phenomenon is not new, it is worsening.

Between 1983 and 1986, Puerto Rican persons under the age of 65 accounted for over 25% of Medicaid cases, compared to 18% of African-American persons and 3% of non-Hispanic Whites. A substantial number of Puerto Ricans tend to use the hospital emergency room for basic medical care. Only 62% of Puerto Rican mothers received prenatal care in the first trimester of pregnancy, compared to 82.7% of non-Hispanic Whites. These statistics illustrate that although Puerto Ricans are covered by Medicaid more than any other ethnic group, the condition of their health care has not improved.

Aside from being under- or uninsured, which is a problem in and of itself, there are other intrinsic barriers which keep Puerto Rican families from getting the best possible care. Such barriers result from unfriendly and often demeaning service providers, inaccessible clinics with overworked staff, a critical shortage of private primary health care providers, a crumbling public health system, bureaucratic hassles, and a lack of bilingual and culturally knowledgeable medical staff to treat Puerto Ricans.

Moreover, population projections for Puerto Ricans suggest that under the current health care delivery model the number of unserved or underserved Puerto Ricans may soon reach alarming proportions. In other words, with a 35% increase in the U.S. Puerto

Rican population during the last decade, the need for affordable and adequate health care is essential for the future of the Puerto Rican community. Any reform in health care must be focused and sensitive to the traditionally underserved populations such as the Puerto Rican community.

### The Extent of the Puerto Rican Health Care Crisis

- ◆ Almost five percent of Puerto Ricans use the hospital emergency room for basic medical care, compared to 0.8% of Mexican-Americans and 0.2% of Cuban-Americans.
- ◆ During the period from 1985 to 1988, Puerto Rican persons between the ages of 45 and 64 used a physicians office only 4.8 visits per person compared to African-Americans (5.6 visits per person) and non-Hispanic Whites (6.5 visits per person).
- ◆ Puerto Ricans had the highest infant mortality rate of 12.3% between 1983 and 1985 which is 3% greater than the rate of the general population.
- ◆ Puerto Rican mothers are almost twice as likely to give birth to underweight babies (9.4%) than non-Hispanic Whites (5.7%).
- ◆ Heterosexual IV drug users account for 40% of Hispanic AIDS cases. In Puerto Rico this figure stands at 58%.
- ◆ In New York City, where the majority of Hispanics are Puerto Rican, 60% of Hispanic women contracted AIDS through drug injection, compared to 31% who were infected through sexual intercourse.
- ◆ In New York City, 54% of Hispanic men contracted AIDS through IV drug use, compared to 36% of men who were infected through homosexual contact.
- ◆ The number of Hispanics aged 12 and over who had used illegal drugs between 1985 and 1988 increased by 1.1 million.
- ◆ Cocaine use by Hispanics grew by 4% between 1985 and 1988.
- ◆ Forty-one percent of Hispanic IV drug users have never been in treatment.

### Recommendations

The health care reform process should bring to your attention the plight of the Puerto Rican community, a group which has been underserved by the present health care system. Although it will be difficult to design a single benefit package that meets the very diverse health care needs of our entire United States population, the federal government should mandate a package which provides a basic level of coverage guaranteed to everyone. Any legislation designed to address American health care needs must include the following:

- ◆ An emphasis on primary and preventive services to help move the focus of the health care system away from treating illness and toward maintaining good health.
- ◆ Preventive health care services which include comprehensive reproductive services such as prenatal and postpartum care, and family planning.
- ◆ Services for infant care and childhood immunizations.
- ◆ Support services needed by low income families with special health care needs.
- ◆ Support of current public health programs until further reforms can be developed



and implemented.

- ◆ Funding for health care providers, such as community health centers, which attend to the needs of underserved populations.
- ◆ Funding for primary health care services which are community-based to provide the Puerto Rican community with services and information on immunization, preventive, and prenatal care, among others.
- ◆ Medical services which include mental health and substance abuse treatment services.
- ◆ Special services and supplies for children with special health care needs or especially vulnerable children from poor families, which include home visiting, respite care, early intervention, social work and nutritional services.
- ◆ Services that assist low income patients receiving health care which include language translation and transportation services, child care coordination and counseling.
- ◆ An expansion of ambulatory health services, particularly those which incorporate bilingual services and cultural sensitivity.
- ◆ Targeted resources for AIDS prevention, education, and treatment for Puerto Ricans.
- ◆ Greater support for outpatient health care delivery to download certain services from the hospital based setting.
- ◆ Support for new programs designed to halt the spread of drug abuse through utilizing the resources of churches, schools and the private sector.

In addition to the above recommendations for the health benefit package, the federal government must pursue greater reform in the health care system to eradicate current inequities. The recommendations below represent reforms to achieve greater equity within the system:

- ◆ Support for hospitals and clinics with staff who understand the distinctiveness of the Puerto Rican community and who are culturally sensitive to Puerto Rican issues, such as kinship and family.
- ◆ Increased spending on student aid programs and give-back arrangements to encourage Puerto Rican students to pursue studies in the medical field, and subsequently work in underserved Puerto Rican areas.
- ◆ Federal support for a "Nurse Practitioner Corps" in which an existing cohort of culturally sensitive nurses would be retrained and directed as nurse practitioners into underserved Puerto Rican locales.
- ◆ An increase in Medicaid benefits provided to residents of Puerto Rico. Although not ideal, a proposed hike of \$25 million over 5 years should be enacted as soon as possible to help the Island deal with its health care crisis.

### Conclusion

Mr. Chairman, members of the Committee, Puerto Ricans in the United States are law-abiding citizens who care about their families. Puerto Ricans are patriots and their children have been serving in the defense of our country for the better part of this century. Puerto Ricans, like all Americans, are pursuing the "American dream," but some

things can not be achieved if the playing field is uneven.

To provide decent and sufficient health care coverage for all Puerto Ricans, quality investments must be made. Not only must access to insurance for Puerto Ricans be increased, but the coverage provided by this insurance must respond to the unique and special health care needs of this community. The National Puerto Rican Coalition and the Puerto Rican community expect no more or no less from the federal government.

Once again thank you for the opportunity to submit a written statement. Any questions would be welcomed.

Please direct any questions to:  
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## Statement of

**Ronald J. Streck, President  
National Wholesale Druggists' Association**

**INTRODUCTION**

With health care reform a national concern, the government is facing the difficult challenge of expanding access to high quality health care services at an affordable price. As a vital link in the delivery of pharmaceutical care to America's consumers, the wholesale drug distribution industry stands ready to help the country meet those goals.

The National Wholesale Druggists' Association (NWDA) is the national trade association for full-line, full-service drug wholesalers. Its members operate 250 distribution centers across the country that handle more than 98 percent of the wholesale sales of pharmaceutical products nationwide. With an effective income tax rate of 32 percent, the industry contributed more than \$230 million in taxes in 1991, not including the taxes paid on wages for the more than 14,000 Americans the industry employs.

Today, the wholesale drug distribution channel is unquestionably the most cost-effective means for pharmaceutical manufacturers to deliver product to market. Drug wholesalers distribute approximately 75 percent of prescription drugs in the United States, up from 57 percent in 1980. This increasing market share reflects the efficiencies and value-added services that wholesale drug distributors offer both their suppliers and pharmacy customers.

The wholesale drug distribution industry has a strong record of innovation and efficiencies. As a result, it has saved billions of dollars in the health care marketplace through lower operating costs. Drug wholesalers dramatically lowered their operating expenses from 9.2 percent of net sales in 1979 to 4.4 percent in 1991. This in turn allowed drug wholesalers to lower their gross margins from 11.3 percent of net sales in 1979 to a slim 6.8 percent in 1991. As a result, the industry's sales grew from \$5.5 billion in 1979 to \$36.2 billion in 1991. On this amount, the industry earned a net profit of just over 1 percent.

Operating in a highly competitive marketplace, wholesale distributors have passed the savings from lower operating costs on to their customers. These customers constitute the entire range of health care facilities: independent retail pharmacies; chain drug stores and warehouses; hospital pharmacies; supermarkets with pharmacies; clinics; HMO and managed health care pharmacies; nursing homes; physicians; mail order; mass merchandisers' pharmacies; prisons; and state and federal institutions.

The latter category — government institutions — is rapidly increasing as a customer of wholesale drug services. Sectors of the federal government, with the Department of Veterans Affairs (DVA) and the Department of Defense (DOD) being dramatic examples, have recognized that their manufacturer-direct purchasing systems are inefficient. In 1990, the DOD evaluated its inventory system and recommended increased use of commercial distribution systems, stating that “increasingly constrained resources and facilities are unnecessarily tied up through investment in material and warehousing of items [that are] available through commercial distribution systems.” A December 1991 report from the General Accounting Office further recommended that the DOD use commercial practices to achieve greater efficiencies. Another government-study, published in September 1992 by the Logistics Management Institute (LMI), reached similar conclusions in regard to the DVA. It noted that the DVA “is testing a new distribution system — based on commercial distribution models — that is reducing inventories and improving response time.” LMI added, however, that the DVA must change more aggressively “to significantly improve responsiveness and reduce distribution costs.” Since those reports, the DOD and DVA have turned to commercial wholesale drug distributors to save millions in expenses while improving service.

NWDA wholesaler members also provide their customers with a multitude of value-added services, ranging from inventory management support and computerized business management reports to pharmacy computer systems and coded shelf labels. In addition, through investment in state-of-the-art distribution and information technologies, the industry has increased its ability not only to save money, but to offer nearly error-free order fulfillment on a standard turnaround of 24 hours or less.

Besides providing timely, accurate and cost efficient distribution of health care products, the wholesale drug industry also provides safe distribution. Wholesale drug distributors are government-licensed operations and adhere to stringent storage and handling procedures designed to ensure the integrity of the medications they distribute and to keep product from being diverted into illicit channels. Wholesale drug distributors adhere to strict procedures with respect to such issues as recordkeeping, security, temperature and humidity requirements, personnel training, return and recall handling, emergency planning, and receipt and distribution of products.



## THE NEED FOR A PHARMACEUTICAL BENEFIT

Because its members are committed to providing efficient and safe delivery of pharmaceuticals to the health care marketplace, NWDA is equally committed to the belief that the cost-effective chain of pharmaceutical benefits be extended beyond the delivery truck. NWDA believes that any minimum health care benefits package should include coverage of pharmaceutical therapy and care to ensure that consumers have guaranteed access to one of the most cost-effective and beneficial portions of the medical care system.

Appropriate pharmaceutical therapy and care not only improve the quality of life for millions of Americans, but also help lower overall health care expenditures by reducing the need for more costly medical interventions — such as surgeries, hospitalizations, long-term institutional care and repeated visits to a physician — and by improving premature morbidity and mortality rates, especially among infants. To give just a few examples, a study by California's Medi-Cal system found that the use of a prescription medication to avert coronary events by reducing blood fats produced annual savings of more than \$5 million. In another example, a DVA study found that for many patients medication was as effective as coronary artery bypass surgery while costing \$300 a year compared to \$41,000 for surgery. Finally, former Health and Human Services Secretary Louis Sullivan stated last year that new drugs to treat respiratory distress have cut infant deaths 8 percent a year since 1989. These are just a few of the many examples that could be cited to show the positive impact pharmaceuticals have.

## GUARANTEEING PHARMACEUTICAL THERAPY

Under the current system, appropriate pharmaceutical therapy is far from guaranteed for health care consumers. In many cases, pharmaceuticals represent the largest out-of-pocket expense for consumers. The ability to pay is directly related to patient compliance and therapy outcome. Simply put, if patients do not have access to pharmaceuticals because they cannot afford the out-of-pocket expense, therapy can be incomplete, mismanaged or never initiated. When treatment fails at this point, it quite obviously is a waste of resources, and more importantly, could seriously impair the patient's health and quality of life. It also is more likely to lead to a greater total treatment cost if more serious and expensive intervention is then necessitated.

NWDA advocates that any minimum health care benefits package should include all components of a proper course of therapy. This includes coverage not only of out-of-hospital prescription drugs, but, when deemed necessary by a licensed health-care practitioner, over-the-counter (OTC) medicines and medical appliances as well. All of these products, when utilized under the proper supervision and direction of a licensed health-care practitioner, are essential to an individual's health and well-being.

## **GUARANTEEING PHARMACEUTICAL CARE**

Coverage of pharmaceutical products is only the first step in ensuring that both the patient and the health care system receive the greatest benefit from pharmaceutical therapy. A complete pharmaceutical package also should include coverage for pharmaceutical care and services. The pharmacist, working in conjunction with the rest of the health care team, can have a great impact in managing a patient's course of drug therapy to ensure that a patient complies with treatment instructions. The pharmacist also can review that the proper medication is prescribed in the proper dosage for a given patient and that treatment is compatible with other medications a patient may be taking. By working to achieve optimum outcomes, these measures address both the quality of health care treatment and cost efficiency.

Any pharmaceutical benefit should recognize that patients may need different levels of pharmaceutical care. To maximize therapeutic outcomes — thus providing the most effective and economically sound treatment — a pharmacist must manage the drug-use process by addressing a patient's individual needs. Thus, any pharmaceutical benefit should encourage and support access to a wide range of services — including drug utilization review and patient outcome analysis — and provide the pharmacist the flexibility to tailor the services to the individual patient.

## **SUMMARY**

The goal of health care reform should be to promote efficient, cost-effective and beneficial treatment. With that objective in mind, a full-fledged out-of-hospital pharmaceutical benefit is a required element of a minimum benefits package in a successful health care reform plan.

An efficient and cost-effective system for delivering pharmaceutical products and care — from the discovery of the drug in the research center

through the warehouse until the patient is declared well — is in place today. At just 7 percent of the nation's health care expenditures, pharmaceuticals and related health care products — when utilized in the proper manner and under the appropriate supervision — are among the most cost-effective methods of health care available. Under the current health care system, however, pharmaceutical care is underutilized to the detriment of both the patient and the system.

Wholesale drug distributors offer dramatic proof that it is possible to reduce costs while increasing quality service. Wholesale drug distributors have made and will continue to make a significant contribution to reducing the bottom line on health care expenditures. We welcome the opportunity to work with this subcommittee, Congress and the administration as we all strive to ensure that the American public receives both the best and the most cost-effective health care.



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**STATEMENT OF THE  
RENAL PHYSICIANS ASSOCIATION  
TO THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
FOR THE RECORD OF THE HEARING  
MARCH 30, 1993**

**RE: HEALTH CARE REFORM:  
CONSIDERATION OF BENEFITS FOR  
INCLUSION IN A STANDARD  
HEALTH BENEFITS PACKAGE**

The Renal Physicians Association (RPA) is taking this opportunity to provide a statement to the House Ways and Means Subcommittee on Health for the record of the March 30, 1993 hearing on consideration of benefits for inclusion in a standard health benefits package.

RPA is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

**Health Care Reform and Consideration of Benefits for Inclusion in a Standard Health Benefit Package**

As you are well aware, the President's Health Task Force chaired by Hillary Rodham Clinton is in the process of developing a standard benefit package for all Americans. With health care reform closer now than ever, the RPA is very concerned that the standard (basic or comprehensive) benefit package offered in any health care reform proposal specifically include all medically necessary renal related services including dialysis and renal transplantation.

The Medicare End-Stage Renal Disease (ESRD) program covers almost 93 percent of ESRD patients or approximately 150,000 individuals. While this program should remain intact as part of health care reform<sup>1</sup>, there are a growing number of individuals who are not eligible for the Medicare ESRD benefit but who need ESRD services<sup>2</sup>. We believe it is therefore necessary to cover these individuals under the standard package. RPA would urge this committee to ensure that all Americans are covered for medically necessary renal related services including renal dialysis and transplantation either through the Medicare ESRD program or through a standard benefit package that all health plans or employers would have to provide.

rpaubcm.sta/bjp

<sup>1</sup> Although an assessment of the Medicare ESRD program within a new health care system should follow, the program could now serve as a model for health care reform. With prospective capitated payments for dialysis related physician services and treatments, the ESRD program is a model of cost effective managed care. In fact, according to HCFA's own data, per patient costs have decreased over time. This virtual single payer system (for a specific disease) has contained costs, expanded access to quality care and lengthened life expectancy.

<sup>2</sup> Kidney Failure and the Federal Government, Institute of Medicine (1991).





**RESOLVE**  
National Office

**Infertility: Education Advocacy Support**

1310 Broadway, Somerville, MA 02144-1731

Business Office 617/623-1156

Helpline 617/623-0744 Fax 617/623-0252

**Testimony of Diane Aronson**  
**Executive Director, RESOLVE, Inc.**

*the national organization serving the infertile population*

Mr. Chairman, thank you for the opportunity to present testimony to the Health Subcommittee of the House Ways and Means Committee for inclusion in the record of the hearing on "Health Care Reform: Consideration of Benefits for Inclusion in a Standard Health Benefits Package" held on April 22, 1993 in Washington, D.C.

I am Diane Aronson, Executive Director of RESOLVE, a national grassroots, non-profit consumer group that supports those suffering from the medical concerns of infertility. There has been a widespread lack of education and sensitivity about the issue of infertility. As you review health care reform, we implore you to consider that one out of six couples are infertile and striving to have a family. Simply, infertility is the abnormal functioning of the reproductive system and needs to be evaluated as any other health care problem.

I should like to present to the Subcommittee the following two RESOLVE documents which state the rationale for the inclusion of infertility treatment in a health care benefits package and the explanation of "medically-appropriate" treatments for infertility.

Thank you again for the opportunity to present our views. As you deliberate on the critical issues of health care reform, we ask that you consider the nearly five million Americans who suffer from the disease of infertility.



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### **Rationale for the Inclusion of Infertility Treatment in a Health Care Benefits Package**

● **Infertility, a disease that affects 4.9 million Americans, is the abnormal functioning of the reproductive systems of both men and women (1/3 women, 1/3 men, 1/3 a combination or unknown cause).**

● **Infertility treatment coverage is an issue of fairness.** How can other important medical problems such as knee surgery be included for coverage and the problems of an abnormally functioning reproductive system be excluded from benefits package?

● **There is a misconception that infertility treatment is costly.** This is due primarily to the mass media's focus on the new technology for treatment. In fact, only 1.6% of those seeking treatment move on to address their infertility through procedures such as in vitro fertilization (IVF). For women who have had diseases that caused the destruction of their fallopian tubes, IVF can be an appropriate and less expensive treatment than tubal surgery.

● **There is a perception that infertility treatment is elective and it is often compared to cosmetic surgery.** Infertility is a medical condition. It is discriminating to eliminate coverage.

● **Why don't people just adopt?** Individuals start off with a life-vision of having their own biological children. It is important to resolve all medical problems before moving on to other ways of achieving a family. Although 2.3 million couples confront infertility there are less than 50,000 children available for adoption each year. Adoption is not an easy option to pursue and can cost up to \$30,000. Most do not have this financial resource and for many individuals an inexpensive treatment can solve their infertility.

● **Finally, our country places a great deal of emphasis on its acknowledgement of the importance of families.** Families are the most important part of our lives and we cannot have a national policy of health care that deprives 2.3 million couples of a family.



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## Medically-Appropriate Treatments for Infertility

Couples afflicted with infertility—the abnormal functioning of the reproductive system—suffer from a wide range of primary causes of their disease. Medical procedures used to treat infertility vary from the simple (hormonal therapy) to the complex (assisted reproductive technologies, or "ART"). Coverage for medically-appropriate treatments for infertility is necessary and should be included in health care proposals.

Assisted reproductive technologies (which include the procedures *in vitro* fertilization, or "IVF", gamete intrafallopian transfer, or "GIFT" and zygote intrafallopian transfer, or "ZIFT") are often misunderstood and thus subject to unusual scrutiny within health care reform efforts. Limiting the availability of specific treatments is not recommended for the following reasons.

- The majority of infertile couples are treated successfully by low-cost conventional procedures. Fewer than 2% of the 1.3 million women who sought treatment for infertility in 1988 utilized the ART.<sup>1</sup>

- All infertility treatment costs, as a portion of total health care, are extremely small and the ART procedures constitute only a tiny fraction of infertility treatments utilized. In 1987 only one tenth of one percent of the total U.S. health care budget was spent on infertility services, and ART accounted for only three hundredths of a percent of health care costs.<sup>2</sup> The experience in states such as Maryland and Massachusetts, where IVF and other ART treatments are mandated, gives strong, documentable support for this.<sup>3</sup>

- One of the reasons that ART is a relatively minor portion of infertility expense is that not all infertile couples undergo the ART procedures, for reasons unrelated to cost.<sup>4</sup>

- ART is the only treatment available for some couples. IVF was originally designed, and is still most commonly used, to treat women who are infertile because of damaged or absent fallopian tubes. For these women, IVF is the simplest, most effective—if not only—medically appropriate treatment for their infertility.

- Because they are successful treatments, IVF, GIFT and ZIFT are considered to be non-experimental. The American College of Obstetricians and Gynecologists, and the American Fertility Society, whose memberships are constituted largely of providers skilled in diagnosing and treating infertility, agree that these procedures are no longer experimental.<sup>5</sup> In recent years data on the ART techniques have demonstrated that they are successful treatments. Since IVF was first introduced in the U.S. in 1980, almost 16,000 babies have

been born from ART. The U.S. IVF Registry reported that, in 1990 alone, a total of 5,193 babies were born as a result of ART. The overall live birth rate in 1990 for IVF was 14%, and for GIFT was 22%.<sup>6</sup> **ART figures must be compared with the 20% chance in any given month that reproductively normal couples have of achieving a pregnancy.**

- If medical protocols are considered in isolation, wasteful costs increase substantially. Before the development of IVF the only treatment available for blocked fallopian tubes was surgical repair of the tubes, an expensive, invasive and largely ineffective treatment. Limiting availability of ART, an outpatient procedure, will likely mean that physicians, in treating their patients, will return to surgery, which in addition to being more expensive and less effective than IVF requires lengthy hospital stays and weeks lost from work.<sup>7</sup>

- Isolation of specific treatment protocols is the antithesis of a streamlined health care system. The inclusion of medically-appropriate treatments for the disease of infertility in health care proposals will rectify inconsistencies in coverage, and is truly a clarification of benefits already partially provided.

SINCE THE NATIONAL HEALTH CARE REFORM PACKAGE IS GOING TO INCLUDE THE TERM "MEDICALLY APPROPRIATE", THIS WILL ASSURE THAT ONLY NECESSARY TREATMENT FOR INFERTILITY WILL BE COVERED.

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1. "Fertility Clinic Success Rate and Certification Act of 1992", Report 102-624, 102nd Congress, U.S. Congress, 1992.

2. *Infertility: Medical and Social Choices*, US Congress, Office of Technology Assessment, 1988.

3. Letter to D. Clements from J. Picciotto, Vice Pres. Blue Cross/Blue Shield of Maryland, April 24, 1990; Letter to S. Crockin from N. Turnbull, Dep. Comm., Mass. Division of Insurance, December 31, 1990.

4. Op. Cit., ref. 1 above; Personal Communication from Dr. Howard Jones, Jones Institute for Reproductive Medicine, Norfolk, VA.

5. The American Fertility Society, "Policy Statement on Insurance Coverage/non-Experimental Procedure", July 1991; The American College of Obstetricians and Gynecologists, "Ethical Issues in Human In Vitro Fertilization and Embryo Placement" (1986), "Guidelines on Gamete Intrafallopian Transfer" (1989), and "Guidelines on Zygote Intrafallopian Transfer" (1993).

6. The American Fertility Society, Press Release on Fifth Annual Report of the U.S. IVF Registry and Related Procedures, January 10, 1992.

7. Holst, N., et al., 1991. "Handling of tubal infertility after introduction of in vitro fertilization; changes and consequences". *Fertility and Sterility*, v. 55(1), pp. 140-143.



**STATEMENT OF MARGARET T. SINGER, Ph.D.**  
**Clinical Psychologist and**  
**Emeritus Adjunct Professor of Psychology**  
**University of California, Berkeley**  
**TO THE SUBCOMMITTEE ON HEALTH**  
**COMMITTEE ON WAYS AND MEANS**  
**U.S. HOUSE OF REPRESENTATIVES**  
**March 30, 1993**

I want to thank Chairman Stark and members of this Subcommittee for your leadership in studying our nation's health care needs in order to rectify serious omission: and develop a standard health care package. I have been a clinical psychologist for over 40 years. I am an emeritus adjunct professor of psychology in the psychology department of the University of California, Berkeley, a former President of the American Psychosomatic Society, a member of the American Psychological Association and a recipient of the NIMH Research Scientist Award. My curriculum vitae is separately provided to the Subcommittee.

My present purpose is to call attention to a most vulnerable, often-overlooked segment of the population that desperately needs health care of many kinds but totally lacks health insurance. I refer to thousands of people who exit from the numerous destructive cult groups each year, sometimes after a dozen or more years outside of mainstream society. In recent years, we have seen not only individuals, but whole families emerge together, ranging in age from grandparents to small children.

I have counseled, befriended and worked with roughly 3,000 cult veterans, both personally and professionally, over the past 24 years, probably more than any other individual health care professional in the United States or elsewhere. As a result, I am acutely troubled by cult veterans' problems in securing medical and mental health care, including residential and outpatient help as needed.

Many people in cult groups regress as to their independence of thought and action and become highly dependent on their group and its leaders for day to day decisions and arrangements of all kinds. Virtually none of these groups arranges any kind of medical or dental insurance or retirement plan for members. Rarely do these groups attend to medical and dental needs of members. Cult leaders may regard expenditures on health care to be "wasteful;" they commonly blame illnesses of members or their children on their own faulty behavior.

As a result, cult veterans exit with no insurance coverage. All too often, they suffer from physical and mental health problems. In many cases, needs may have accumulated unattended during the period of cult membership. In any event, when needs may arise after exit there is no insurance coverage and, very often, little grasp of how to go about securing help. To illustrate these problems of cult veterans, let me offer two cases (changing the names in order to preserve anonymity):

**KAREN:** A twenty-five year old woman with two young children fathered by the leader of the small cult she had been in for eight years, ran away during the night because of her fear of the cult leader who beat her, the various children and his other "wives." He recently had enforced his demands by shooting guns off inside the large building the group occupied and had begun to use street drugs. Earlier, Karen had renounced her parents at the behest of the cult leader and lost contact with them.

With the children, she had run to an all-night diner where a trucker gave them a ride to another city, as Karen feared the cult leader would be looking for her. The trucker left her at a police station, as he told Karen she needed someone to look after her. She and the children were taken to a women's shelter. Both she and the children were not well. Residency and other requirements precluded Karen from getting help. Karen learned of my name as someone who helped people who had been in cults. She visited my office and we were able to reach her mother by phone and reestablish that family tie. Karen stayed at the shelter a few days until her mother arrived by car from another state and took Karen home. Karen called to thank me and asked how she might get medical help in her mother's state. As with many cult veterans, she had no idea of how to seek help, etc. I suggested several agencies.

Margaret T. Singer, Ph.D., statement for the printed record of  
Subcommittee on Health of the Ways and Means Committee of the  
U.S. House of Representatives - March 30, 1993, hearing

After some months, I received a phone call from an agency to discuss with me the cult leader and the potential danger he posed to Karen and the children if he knew where they were.

**MARK:** Mark at age 27 left a cult he had been in nine years. Since leaving the cult some months before he first met with me, he had been living in an old car, working at odd jobs, and was given small stipends by a private charitable organization which referred him to me. He looked emaciated, had a hacking cough, and said he had not felt well for a long time. In addition to his physical needs, I felt that he needed psychiatric evaluation, for his severe depression. But he had no insurance, no money, and had long been estranged from his family at the orders of his cult leader who had told him to "disconnect" from them. We did not succeed in reestablishing family ties. When last heard from, Mark had abandoned the car and hitchhiked to another state. Mark wrote that he was still ill, depressed and unable to get help.

Lucky cult veterans have families from whom to seek help. Others have to rely on welfare -- if they can find it -- until they can establish themselves. Often they have no where to go, no family or friends available to help. In some cases the cult veteran doesn't understand how to enlist help.

Most seek minimum wage jobs and temporary work because life in the cult group ended education and significant job training, their work in the cult having consisted of seeking contributions, recruiting others and the simplest forms of labor.

Help available now to cult veterans is all volunteer and mainly educational and psychologically supportive help. The degree of need varies, of course, from veteran to veteran.

No adequate survey has ever been undertaken of the degree of exposure to such cult groups. There are about 5,000 such groups in the United States, some large, some very small. I estimate that about 10-20 million people have at some point in recent years been in one or more of such groups.

It is extremely important to the well-being of these cult veterans that a new program cover their emotional and mental rehabilitation needs, as well as continuing health needs of all kinds, including preventive, out-patient and residential treatments. It is extremely important that the program include social work guidance that will help the regressed, immature cult veteran regain or develop an adult competence to manage day to day affairs. It is extremely important that such workers and other helping professionals in the program understand how cultic influence and control impacted the ex-members. Except in rare circumstances, ex-cultists need psycho-educational and social work help before traditional psychotherapy can be of benefit to them, should such therapy be needed at all.

In closing, let me note that these so-called cults are by no means all religiously oriented. Cults form around many themes, including political, racial, and psychotherapy themes. Common threads include loss of independence and critical thinking skills and extreme reliance on leaders. The end result for you to consider is a desperate lack of vital health care.

I will be happy to provide any further information the Subcommittee may need. Thank you again for all your important work and for considering this statement.

**STATEMENT OF AUXILIARY BISHOP JOHN H. RICARD, S.S.J., CHAIRMAN  
OF THE DOMESTIC POLICY COMMITTEE OF THE UNITED STATES  
CATHOLIC CONFERENCE**

Health care reform is not a new issue for the U.S. Bishops' Conference. In 1971 and again in 1974, the U.S. Catholic Conference, with the then National Conference of Catholic Charities and Catholic Hospital Association, presented testimony before the Committee on Ways and Means regarding our concern that reform proposed for the health care system in this country should provide access to the poor and unserved and protect the dignity and sanctity of human life and the human community.

In our 1981 pastoral letter **Health and Health Care**, we called for an adequately funded national health insurance program for all Americans. This call is rooted in a belief that every person possesses an inherent dignity that must be respected, and every person has the right and the responsibility to realize the fullness of that dignity. The inherent dignity of human life also gives rise to basic human rights, among which is the right to health care. Such a right implies that access to health care which is necessary and appropriate for the proper development and maintenance of life must be provided for all people, regardless of economic, social or legal status. We appreciate having another opportunity to contribute to the important ongoing national debate about the reform of the health care system in the United States.

The specific issue we address before the Committee at this time is the nature of the benefits to be included in a comprehensive benefits package, which in turn will set the requirements for health care plans. We speak about this issue as leaders of a faith community deeply involved in providing quality health care in almost 900 hospitals and nursing homes; in numerous home health agencies; and through Catholic Charities agencies and parish-based ministries across the country. We have seen the consequences of a failed and confused national health policy - families without insurance, children without necessary care, the sick and dying without options. But it is the poor who suffer most acutely from the faults and failings of the nation's health care system. It is their pain and suffering, their poor health and sickness, that sharpens our resolve to join in the call for genuine reform now. We have expressed our views twice over the past year in letters to members of Congress and to First Lady Hillary Rodham Clinton. [See attachment]

We believe that a comprehensive benefits package must provide benefits sufficient to maintain and promote good health and to treat disease, injury, and disability appropriately. Benefits must be provided to care for persons who are chronically ill or dying, and the package must help promote and protect the public health of the population through community and migrant health centers. We believe that a mandated package of benefits should include not only direct health services but also supportive services which have been demonstrated necessary for effectively serving the poor, the aged, the disabled and those with special health problems, such as alcoholism and drug abuse. It would also be inconsistent with a commitment to provide universal access to allow pre-existing condition exclusions or waiting periods.

We believe that each person should have available:

1. Primary medical care with an emphasis on a freely chosen, responsible health care provider, who is properly supported by ancillary personnel and provides access to specialists and other appropriate referrals and consultation when necessary.

2. Emergency care with appropriate follow-up.

3. Hospital in-patient and out-patient services for both medical and psychiatric care.

4. Post-hospital extended care, nursing home care, home health services, therapeutic and rehabilitative services.



5. Prescription drug coverage.

6. Dental care, especially for children.

Our nation's continuing failure to guarantee access to quality health care for all people exacts its most painful toll in the preventable sickness, disability, and deaths of our infants and children. Beginning with children and their mothers, we must extend access to quality health care to all our people. Quality and accessible prenatal care is essential for healthy children. There can be no excuse for the failure to ensure adequate health care and nutrition for pregnant women. Nothing would make a greater contribution to reducing infant mortality than progress in this area. If the health reform plan phases in universal health coverage, then pregnant women and children must be among those covered first.

The special needs of children must be recognized by providing access for all children to comprehensive services equivalent to those now available under the early and periodic screening, diagnosis, and treatment (EPSDT) program. The special needs of women must be recognized by covering a full range of health services, such as prenatal and maternity care for all women of child-bearing age, including high risk women needing special maternity services. In addition, provision must be made to assure access for low income and other high risk families through such means as outreach, bilingual/bicultural services, case management, transportation and home visits.

As I said at the beginning of my testimony, our commitment to national health care reform is rooted in a belief that every person possesses an inherent dignity that must be respected, and every person has the right and the responsibility to realize the fullness of that dignity. The right to health care arises from the fundamental dignity of each human being. It would undermine the very foundation for the right to health care to advocate for benefits which violate respect for the dignity of human life. Therefore we firmly maintain that abortion should not be included in the benefits package. Health care, by its very nature, must include protection of the child in utero as well as providing care once the child is born.

We believe it would be a moral tragedy, a serious policy misjudgment and a major political mistake to burden health care reform with abortion coverage that most Americans oppose and the federal government has not funded for the past 17 years. Public opinion surveys over the past twenty years have consistently shown that most Americans oppose abortion on demand and the use of federal funds to pay for such abortions. In addition, a New York Times poll, reported in April, indicated that three out of four Americans oppose including abortion coverage as part of national health care reform.

The Catholic community is committed to fundamental reform of the nation's health care system. The measure of the success of health care reform is how fully it meets the genuine needs of the unserved and underserved, especially those who are most helpless and vulnerable. We thank you for the opportunity to discuss our concerns and recommendations with you.





## Department of Social Development and World Peace

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April 16, 1993

Mrs. Hillary Rodham Clinton  
First Lady  
Health Care Task Force  
Old Executive Office Building, Room 287  
Washington, D.C. 20500

Re: National Health Care Reform

Dear Mrs. Clinton:

I write on behalf of the United States Catholic Conference, the public policy agency of the nation's Roman Catholic Bishops, to voice our strong support for comprehensive reform of the nation's health care system. We welcome the encouraging signs that our leaders and people are becoming serious about reforming the nation's health care system.

Our Bishops' Conference brings to this debate strong convictions about health care, human life and human dignity. We bring broad experience as leaders of a community that is the largest non-public provider of health care and a large purchaser of health insurance. We also bring the urgency gained as our community helps those whom the health care system fails. We see first hand the failures and gaps of the current system in our hospitals, shelters, parishes, schools and human service programs.

We hope to make a positive contribution to the vital debate about how our nation should address the problems of limited access, rising costs, and deteriorating quality in many areas of today's health care system.

### Foundations

Health care is not a new concern for the Catholic community. The church has been involved in the delivery of health care services since the early days of this nation. Those early services have grown to make Catholic-sponsored health care facilities the largest network of non-profit hospitals and nursing homes in the U.S., serving about forty million people in a single year. In our parishes and schools, our shelters and clinics, we see the consequences of failed and confused policy — families without insurance, sick without options, children without care.

For more than two decades our Bishops' Conference has advocated comprehensive health care reform. In our 1981 pastoral letter *Health and Health Care*, the bishops called for an "adequately funded national health insurance program for all Americans." This position is based not on political theory, but on our teaching that human life must be protected and

human dignity promoted. These principles lead us to conclude that all people have a right to health care since the lack of health care can destroy the life and dignity of the human person.

When more than 30 million Americans are without health coverage, when rising costs threaten the coverage of tens of millions more, when infant mortality remains shockingly high, and when millions of children are without basic health care, the right to health care is seriously undermined and the health policies of the nation are in serious disarray and in need of fundamental reform.

We bring to the health care debate a special concern for the poor and vulnerable, rooted in both our faith and experience. It is the poor who suffer most acutely from the faults and failings of the health care system. It is their pain and suffering, their poor health and sickness, that sharpens our resolve to work for genuine reform now. In seeking the fundamental changes which are necessary, we especially urge policymakers to assess the impact of national health policies on the poor and the vulnerable.

The Catholic Health Association, which represents almost 600 Catholic-sponsored health care facilities, has developed a comprehensive framework for a reformed health care system. Their proposal for systemic reform combines universal access to comprehensive quality health care with cost control while insuring the care of the poor and preserving human life and dignity. We welcome this impressive plan from leaders of the Catholic health care ministry; it offers important values and policy directions that should help guide the debate and decisions in the months ahead.

### **Applications**

Applying our experience and principles to the choices before the nation, the U.S. Catholic Conference supports a comprehensive health care system that will ensure a decent level of health care for all Americans without regard to their ability to pay. This will require concerted action by federal and other levels of government and by the diverse providers and consumers of health care.

We believe government, an instrument of our common purpose and called to pursue the common good, has an essential role to play in assuring that the rights of all people to adequate health care are met. Attached you will find our criteria for reform which we shared with the Congress last year.

We believe reform of the health care system which is truly fundamental and enduring must be rooted in values which reflect the essential dignity of each person, ensure that basic human rights are protected, and recognize the unique needs and claims of the poor. The health care system we advocate would provide universal access to comprehensive quality care subject to cost containment and controls, characterized by equitable financing and genuine respect for human life and human dignity.

## **Our Major Priorities**

In applying our broad criteria, we have chosen to focus our advocacy on several major priorities:

### **1. Priority Concern for the Poor/Universal Access**

Fundamental health care reform must protect the lives and dignity of all, especially the poor, i.e., those who are unable through private resources, employer support, or public aid to provide payment for health care services, or those unable to gain access to health care because of limited resources, inadequate education or discrimination.

When there is a question of allocating scarce resources, the defenseless and the poor have a compelling claim to special consideration. Others may have alternative ways of shielding themselves and stand less in need of help from the broader community. The poor have fewer resources of their own to fall back on and must often depend on the assistance of the community. Special attention must be given to ensuring that those individuals and communities which have suffered from inaccessible and inadequate health care are first brought back into an effective system of quality care. Therefore, we will strongly support measures to ensure true universal access and rapid steps to improve the health care of the poor and unserved.

### **2. Respect for Human Life and Human Dignity**

Real health care reform can protect and enhance human life and human dignity. Current failures and inadequacies threaten and diminish human life. Lack of access, inadequate care, and infant mortality are literally matters of life and death. We strongly believe every member of the human family has the right to life, to bodily integrity, and to the means which are suitable for the full development of life. This is why we insist that every human being has the right to quality medical care. We do not believe the violence of abortion or euthanasia is consistent with respect for human life. A concern for human dignity is best demonstrated by providing access to quality comprehensive care from the prenatal period throughout infancy and childhood, into adult life and, at the end of life, when care is possible even if cure is not. Therefore, we believe it would be a moral tragedy, a serious policy misjudgment and a major political mistake to burden health care reform with abortion coverage that most Americans oppose and the federal government has not funded for the last 17 years. A recent New York Times poll indicated that three out of four Americans oppose abortion coverage as a part of health care reform.

### **3. Pursuing the Common Good and Preserving Pluralism**

We fear the cause of real reform can be undermined by special interest conflict and the resistance of powerful forces who have a major stake in the status quo. It also can be set back by unnecessary partisan political combat. We believe the debate can

be advanced by a continuing focus on the common good and a healthy respect for genuine pluralism.

A reformed system must encourage the creative and renewed involvement of both the public and private sectors, including voluntary, religious and non-profit providers of care. It must also respect the religious and ethical values of both individuals and institutions involved in the health care system. The Catholic community is strongly committed to continuing to meet the health needs of the nation in a framework of genuine reform, which respects the essential role and values of religiously-affiliated providers of health care.

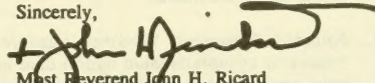
We also insist that any acceptable plan must include effective mechanisms to contain rising health care costs. Without cost containment, we cannot hope to make health care affordable and permit the use of scarce national resources to address other pressing problems, e.g., housing, poverty, and education.

On this basis, we will continue to work for reform of the U.S. health care system. In our view, the best measure of any proposed health care initiative is the extent to which it combines universal access to comprehensive quality health care with cost control, while ensuring quality care for the poor and preserving human life and dignity.

We urge our national leaders to look beyond special interest claims and political differences to fashion a comprehensive response which unites our nation in a new commitment to meeting the health care needs of our people, especially the poor and vulnerable. This is a major political task, a significant policy challenge, and a moral imperative.

We look forward to working with you to achieve comprehensive national health care reform that will strengthen our nation and serve its people.

Sincerely,



Most Reverend John H. Ricard  
Auxiliary Bishop of Baltimore  
Chairman, Domestic Policy Committee



United States Catholic ConferenceCRITERIA FOR HEALTH CARE REFORM

Last year, our Conference shared with members of the House and Senate the following criteria for reform:

1. *Universal Access.* Whether it provides ready universal access to comprehensive health care for every person living in the United States.
2. *Priority Concern for the Poor.* Whether it gives special priority to meeting the most pressing health care needs of the poor and underserved, insuring that they receive quality health services.
3. *Respect for Life.* Whether it preserves and enhances the sanctity and dignity of human life from its beginning to its end.
4. *Comprehensive Benefits.* Whether it provides comprehensive benefits sufficient to maintain and promote good health, to treat disease, injury, and disability appropriately, and to care for persons who are chronically ill or dying; and whether it ensures government's responsibility for the public health of the population.
5. *Pluralism.* Whether it allows and encourages the involvement of the public and private sectors, including the voluntary, religious, and non-profit sectors, in the delivery of care and services; and whether it ensures respect for religious and ethical values in the delivery of health care for consumers and for individual and institutional providers.
6. *Equitable Financing.* Whether it assures society's obligation to finance universal access to comprehensive health care in an equitable fashion, based on ability to pay; and whether proposed cost-sharing arrangements are designed to avoid creating barriers to effective care for the poor and vulnerable.
7. *Cost Containment and Controls.* Whether it creates effective cost containment measures that reduce waste, inefficiency, and unnecessary care, that control rising costs of competition, commercialism, and administration, and that provide incentives to individuals and providers for effective and economical use of limited resources.
8. *Quality.* Whether it promotes the development of processes and standards that will help to achieve equity in the range and quality of services, in the training of providers, and in the informed participation of consumers in individual and societal decision-making on health care.

These criteria will continue to guide our advocacy .

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